

**TOM PRICE, M.D.**

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**Congress of the United States**  
**House of Representatives**

April 8, 2010

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CHAIRMAN

DEPUTY WHIP

VIA FACSIMILE

Ms. Andrea Palm  
Acting Assistant Secretary for Legislation  
U.S. Department of Health and Human Services  
Hubert Humphrey Building, Room 416 G  
200 Independence Avenue, SW  
Http://www.hhs.gov/  
Washington, DC 20201-0001


Dear Ms. Palm:

My constituent, CAPT (b)(6) has contacted me regarding a problem he is having. Please find enclosed a copy of his correspondence.

Please verify the status of this situation and provide me with any information that I may use to properly assist my constituent. Please forward all correspondence to Tina McIntosh in my Marietta District Office at 3730 Roswell Rd., Suite 50, Marietta, GA 30062. She may also be reached by email at [tina.mcintosh2@mail.house.gov](mailto:tina.mcintosh2@mail.house.gov) or by phone at 770-565-4990.

Thank you in advance for your time and assistance in this matter. I look forward to hearing from you soon.

Yours truly,

  
Tom Price, M.D.  
Member of Congress

TP/tm

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(b)(6)

Congressman Tom Price  
3730 Roswell Road, Suite 50  
Marietta, GA 30062

Dear Representative Price:

I am hoping you can help me get a response from the United States Public Health Service (PHS), as I have been unsuccessful despite repeated inquiries. I was commissioned in the PHS as a Medical Officer in the late 1970s and mandatorily retired in August 2007 after 30 years of active duty. At the time of my retirement, I had 35 years of *creditable service* because the PHS gives physicians credit for 4 years of medical school and 1 year of internship. Annual retirement pay for PHS officers who entered the service when I did is calculated as a percentage of annual base pay. Previously, under Title 42 of the US Code, this percentage was capped at 75%.

In an effort to retain senior officers in the uniformed services, Section 642 of John Warner National Defense Authorization Act for Fiscal Year 2007 removed the 75% cap on retirement pay for officers retiring on or after 1 January 2007. Under this law, the retirement percentage is calculated as 2.5% multiplied by the number of years of *creditable service*. For me, this would equate to 87.5% (35 years x 2.5%) of annual retirement pay rather than 75% (the previous cap removed by Congress) under which I am now paid.

I sent a memo to the PHS in May 2009 requesting a recalculation of my retired pay under the new law, but have never gotten a formal response to my memo. I have e-mailed several people in the PHS, called PHS staff in Atlanta and Washington, and visited the CDC's Commissioned Corps Office. Nonetheless, I am still waiting 11 months later to know what the status of my request is. I cannot even find out who is responsible for providing a response to me. A number of my fellow medical officers with more than 30 years of *creditable service* have retired since 1 January 2007 and also submitted memos to PHS requesting that their retirement pay be recalculated in view of the new law; PHS has not responded to them either.

After nearly a year of runaround, I am frustrated by my government's lack of response to what I believe is a legitimate question. I would greatly appreciate your help in determining the status of our requests for consideration under the new law, what review or other processes are underway to evaluate the issues we raised, and the PHS timeline for addressing this matter.

Thank you for your assistance.

(b)(6)

**TOM PRICE, M.D.**  
6TH DISTRICT, GEORGIA

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**Congress of the United States**  
**House of Representatives**

November 16, 2010

COMMITTEE ON  
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RANKING MEMBER

REPUBLICAN STUDY COMMITTEE  
CHAIRMAN  
DEPUTY WHIP

Mr. James R. Esquea  
U.S. Department of Health and Human Services  
Hubert Humphrey Building, Room 416 G  
200 Independence Avenue, Sw  
Washington, DC 20201-0001

Dear Mr. Esquea:

My constituent, Ms. (b)(6) has contacted me regarding a problem she is having. Please find enclosed a copy of her correspondence.

Please verify the status of this situation and provide me with any information that I may use to properly assist my constituent. Please forward all correspondence to the attention of Tina McIntosh in my Marietta District Office at 3730 Roswell Rd., Suite 50, Marietta, GA 30062. You may also contact her by phone at 770-565-4839, by facsimile at 770-565-7570, or by email to [tina.mcintosh2@mail.house.gov](mailto:tina.mcintosh2@mail.house.gov).

Thank you in advance for your time and assistance in this matter. I look forward to hearing from you soon.

Yours truly,

Tom Price, M.D.  
Member of Congress

TP/tm

Congressman Price, my name is (b)(6) and you are my elected representative.

I have written you in the past, as recently as last month and I appreciate your reply and the assistance you provided me. Today I am writing to express to you my concerns regarding the U.S Department of Health and Services' National Health Service Corp program and the type of health care professionals that are eligible. While this program is a great resource and an amazing way to get more people involved in the health care profession by allowing loan repayment and scholarships for those who dedicate to a minimum service commitment to expand access of health care services and improve the health of people who live in urban and rural areas where health care is scarce, it does not allow for those of use who are dedicating our lives to Nutrition as it relates to overall wellness in these same communities and are also willing to dedicate ourselves to the same kind of minimum service commitment. Nutrition or lack of nutritional education resources happens to be one of the major reasons why our society is in need of extensive health care; it is a trickle down effect that is directly related. We, as a country, are willing to create and educate more people to become doctors, nurses, psychiatrists, dentists, etc but we are not willing to invest in and educate more individuals to focus on our human nutrition and its ability to help conquer diabetes, high cholesterol that leads to heart disease and obesity to name a few.

I would like to know exactly what it would take to include Dietitians and Clinical Nutritionists as a part of this wonderful NHSC program. Besides this correspondence to you, where do I start and to whom else do I reach out to? I am currently enrolling in higher education for a Master in Human Nutrition to become Clinical Nutritionist, something that I am deeply passionate about. My goal is to work in the community to educate our children from the ground up about the importance of eating and being mindful of where our food comes from. My hope is to help eradicate and rehabilitate childhood obesity so that our future does not fall victim to the effects of what the lack of this knowledge will ultimately do to our society in an effort to leave our country in the hands of healthy individuals for generations to come that at minimum have the ability to make better nutritional decisions for themselves. It is imperative that the NHSC program allows for people like me so that others are also influenced to want to be in the Nutrition industry.

Thank you in advance for your time and your help. I look forward to hearing from you.

(b)(6)

**From:** Ammen, Faith [<mailto:Faith.Ammen@mail.house.gov>]  
**Sent:** Tuesday, March 04, 2014 1:40 PM  
**To:** Street, Amanda  
**Cc:** Super, Nora (HHS/ONCIT)  
**Subject:** RE: Mtg w/ Doc Caucus

Hi,

The Congressman is available for 30 min in any of the following times:

March 24: 3-5pm  
March 26: 4-5pm  
April 1: 3-4pm  
April 2: 4-5pm  
April 7: 3-5pm

I do not schedule for the Doc Caucus but 8am time slots that work on our end are:

March 27  
April 3  
May 8  
May 22

Thanks!

**Faith Ammen**

Executive Assistant  
Congressman Tom Price, M.D.  
100 Cannon House Office Building  
[www.tomprice.house.gov](http://www.tomprice.house.gov)

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**From:** Zebley, Kyle [<mailto:Kyle.Zebley@mail.house.gov>]  
**Sent:** Wednesday, December 04, 2013 1:18 PM  
**To:** Salsberg, Edward (HRSA); Atkinson, Leslie (HRSA)  
**Cc:** Street, Amanda; Spitzgo, Rebecca (HRSA)  
**Subject:** RE: GME Reform

Mr. Salsberg,

Thank you very much for following up. Leslie, any help you may be able to provide in pointing us to the right person would be most appreciated.

*Kyle Zebley*  
Senior Policy Advisor  
Congressman Tom Price, M.D. (GA-06)  
100 Cannon House Office Building  
Tel: 202-225-4501  
Fax: 202-225-4656

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**From:** Salsberg, Edward (HRSA) [<mailto:esalsberg@hrsa.gov>]  
**Sent:** Wednesday, December 04, 2013 12:14 PM  
**To:** Zebley, Kyle; Atkinson, Leslie (HRSA)  
**Cc:** Street, Amanda; Spitzgo, Rebecca (HRSA)  
**Subject:** RE: GME Reform

Kyle, glad to hear of the interest in federal GME policies. While the National Center for Health Workforce Analysis collects and analyzes physician workforce data, we are not involved in GME policies. Leslie Atkinson in our Office of Legislation, who I have copied on this email, is in the best position to direct you to the appropriate staff to discuss this issue.

Best of luck in your efforts.

Regards

Ed

Edward Salsberg  
Director  
National Center for Health Workforce Analysis  
Bureau of Health Professions  
Health Services and Resources Administration  
U.S. Department of Health and Human Services  
5600 Fishers Lane,  
Rockville, MD 20857

[esalsberg@hrsa.gov](mailto:esalsberg@hrsa.gov)  
301 443-9355



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**From:** Zebley, Kyle [<mailto:Kyle.Zebley@mail.house.gov>]  
**Sent:** Tuesday, December 03, 2013 10:07 AM  
**To:** Salsberg, Edward (HRSA)  
**Cc:** Street, Amanda  
**Subject:** GME Reform

Mr. Salsberg,

I hope you are having a wonderful morning. Amanda Street and I work for Congressman Tom Price of Georgia. Amanda handles healthcare while I handle education. At the direction of the Congressman, both of us are collaborating on some kind of fix/reform of federal GME policy. In a recent discussion with Dr. Erin Fraher from UNC regarding GME, your name came up as a leading expert on the topic.

Amanda and I were wondering if there was a time in the coming weeks to talk on the phone with you regarding GME. Perhaps a week Congress is out of session, like Dec. 16-20? Let me know if this would work for you. Thanks in advance for your consideration.

***Kyle Zebley***

**Senior Policy Advisor**

**Congressman Tom Price, M.D. (GA-06)**

**100 Cannon House Office Building**

**Tel: 202-225-4501**

**Fax: 202-225-4656**



**From:** [DiBlasio, Carla](#)  
**To:** [Sealy, Camille \(HRSA\)](#)  
**Cc:** [Hacking, Rose \(HHS/ASL\)](#); [Atkinson, Leslie \(HRSA\)](#)  
**Subject:** RE: 340B Concerns  
**Date:** Wednesday, August 24, 2016 6:41:10 PM

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Thanks, Camille.

We appreciate your consideration.

Carla DiBlasio  
Senior Policy Advisor/Legislative Counsel  
Congressman Tom Price, M.D. (GA-06)  
100 Cannon House Office Building  
Washington, DC 20515 | 202.225.4501

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**From:** Sealy, Camille (HRSA) [mailto:CSealy@hrsa.gov]  
**Sent:** Wednesday, August 24, 2016 12:45 PM  
**To:** DiBlasio, Carla  
**Cc:** Hacking, Rose (HHS/ASL); Atkinson, Leslie (HRSA)  
**Subject:** RE: 340B Concerns

Hi Carla,  
I hope this message finds you well.

Thanks for your inquiry regarding HRSA's 340B Drug Pricing Program (340B Program) and the status of the proposed 340B Omnibus Guidance. As you know, the proposed guidance was open for review and public comment in the *Federal Register* (80 FR 52300 (August 28, 2015)) with a 60-day comment period, which closed on October 27, 2015. HRSA is currently analyzing the comments received to develop the final 340B Omnibus Guidance. We are targeting December 2016 for publication of the final guidance. We understand the importance of the 340B Program to you and your constituents and appreciate you reaching out on this matter.

If you should have additional questions, please do not hesitate to reach out.

Sincerely,  
Camille

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**From:** DiBlasio, Carla [mailto:Carla.DiBlasio@mail.house.gov]  
**Sent:** Wednesday, August 24, 2016 11:56 AM  
**To:** Sealy, Camille (HRSA)  
**Subject:** 340B Concerns

Camille,

I hope this email finds you well. I handle healthcare for Congressman Tom Price. Emory University

recently presented us with a list of concerns regarding 340B. We greatly appreciate your attention to their concerns as described in their comments below. Any feedback you can provide us on any of these concerns would also be greatly appreciated.

Emory University Hospital Midtown (EUHM), a 511-bed academic community hospital in the heart of midtown Atlanta, is a strong supporter of the 340B program and its impact on our patients. As a DSH facility in a large urban area, it is our role to ensure access to world-class care to our community's most vulnerable patients. Access to 340B pricing allows us to fulfill this mission and improve the overall health of our city.

EUHM takes compliance with HRSA guidance extremely seriously. We are committed to running a highly compliant program and we are excited to see additional clarifying statements provided in the omnibus proposal. In reviewing the proposed language, we found some content to be of concern and we thank you for the opportunity to provide feedback. Please find a summary of our comments below.

## 1. Hospital Relationships with Their Providers

- a. We do not understand what HRSA intends with the requirement that we have employment or independent contractor relationships with our providers such that we may bill for their services. Currently EUHM has a mix of employed physicians, community / private practice physicians who are active medical staff at EUHM, and GME residents and fellows. We review our list of eligible providers daily to ensure that all providers are active medical staff at EUHM.
- a. We request that HRSA remove this requirement, as the remaining requirements in this area already limit 340B use to services and prescriptions that are written in the hospital or one of its registered locations, thereby ensuring hospital responsibility for the services
- b. If HRSA intends to maintain this requirement, then we request that HRSA revise and republish it for comment. As written, we do not believe we have a meaningful opportunity to comment because the language used is too vague
- c. If HRSA intends for this provision to impose new standards for the health industry regarding provider contracting (e.g., outside of what is currently required by health programs and the Joint Commission), HRSA needs to more clearly articulate what would be required
- b. Issues related to who is an "independent contractor" of the hospital:
  - i. The guidance would require that for a provider to be able to write a prescription or order for a 340B drug, the provider must be an employee or "independent contractor" of the hospital.
    1. While many of our providers are employed through Emory University, our community / private practice physicians are neither employees nor do they have a contract with the facility
    2. All EUHM providers undergo a rigorous credentialing process prior to becoming "active medical staff"
  - ii. Using an "independent contractor" standard is not appropriate for guidelines, as the legal rules in this area are not subject to a national standard and vary significantly by state and even within states.
- c. Issues related to what HRSA means by "may bill for services on behalf of the provider":
  - i. The language stating that hospitals must have arrangements such that they "may bill for services on behalf of the provider" is even more unclear. Does this refer to services that hospitals bill in connection to services furnished by a provider (e.g., the facility fee)? Or does it refer to billing for the professional services furnished by our providers?

## 2. Orders for Infusion

- a. EUHM, as the infusion provider for the nationally recognized Winship Cancer Institute, will reach in excess of 100,000 infusion visits in calendar year 2015. Access to 340B pricing for our infusion center allows EUHM to provide millions of dollars in charity care directly associated with the treatment of hematologic and oncologic conditions, funds direct access to these sites through transportation subsidies, improves overall patient experience through the funding of dietitians, clinical pharmacy specialists, nursing navigators, midlevel clinical providers and clinical nurse educators, and funds a robust patient assistance program for oral therapies and a co-pay assistance program for infusion related therapy. These programs simply could not exist without access to 340B pricing.
- b. The proposed guidance would only allow 340B for infusion orders if they were written as a result of services provided in the hospital or a registered child site.
- c. EUHM owns many of the hematology / oncology clinics that refer patients to our infusion centers but we also accept patients who have been seen at non-EUHM clinics for their medical care.
- d. Individuals receiving infusion at the hospital are unquestionably hospital patients, even if the order is written in a location outside the hospital. The individuals are registered as hospital patients and the hospital is responsible for administering the infusion and is required to provide health care services in conjunction with the drug's administration.
- e. No other government program or other health care payer requires infusion orders to be written at the hospital as a condition of payment. HRSA is proposing a 340B-specific requirement for infusion orders that does not exist anywhere in health care policy.
- f. Administration of infusion drugs are highly complex services, requiring skill and direct attention, and may only be performed by trained health care professionals. Failure to administer infusion drugs appropriately can result in severe consequences for the patient, for which the hospital is responsible.
- g. The concerns about this proposal exist even if GPO pricing were permitted for these drugs.
- h. Imposing this unique 340B standard would require hospitals to develop new tracking systems to distinguish their outpatients for whom an order was written on the premises of the hospital and those for whom the order was written outside the hospital. Since the individuals receive the same hospital outpatient services in both cases, this tracking is not currently necessary and would impose a new burden on safety-net hospitals and is one that may not even be feasible.

## 3. Discharge Prescriptions

- a. The proposed guidance would prohibit hospitals from using 340B pricing for drugs that are billed as outpatient drugs if the script/order was written in connection to a discharge from an inpatient stay.
- b. Using 340B for discharge prescriptions is a longstanding practice that allows 340B hospitals to reduce readmissions for their patients, is easy to administer and audit, and is consistent with the purpose of the 340B program.
- c. As a 340B hospital, we discount the cost of medications provided upon discharge for our low income patients to help ensure that patients can get the drugs they need. Over the last 3 fiscal years, EUHM has provided approximately \$300,000 annually in uncompensated discharge medication to uninsured and low income patients to transition the patient to the next level of care. Without access to 340B pricing for discharge prescriptions, we will not be able to support the same level of support.
- d. Eligibility for 340B pricing should be applied to all drugs furnished in connection to services received at the hospital, for registered hospital patients, and that are billed on an outpatient

basis. This is an easy bright line rule for hospitals to follow and for HRSA to audit. EUHM currently audits 100% of all discharge prescriptions using 340B drugs to ensure that they meet the requirements as outlined in the current guidance.

1. Tracking discharge prescriptions that tie to an inpatient service so they could be excluded from 340B would be operationally challenging and burdensome because hospitals generally do not track in their retail pharmacies whether a prescription resulted from an outpatient encounter. Compliance with the proposed change would require significant modifications to hospital systems.
- e. 340B pricing is available under the 340B statute for “covered outpatient drugs.” There is no requirement under the 340B statute that covered outpatient drugs that are billed as outpatient drugs must also pertain directly to an outpatient service. Indeed, many hospitals are able to participate in the 340B program only by demonstrating that they provide *inpatient* services to a disproportionate number of low income patients. It would be inconsistent with the statute to deny 340B pricing for outpatient prescriptions needed by those low income patients upon discharge.

#### 4. Outpatient Services That Are Not Billed As Outpatient

- a. The proposed guidance would prohibit use of 340B for drugs given to hospital outpatients if the patient’s insurer requires that the outpatient service resulting in the script/order being written be included in a bill for inpatient services.
- b. This new proposed policy would change HRSA’s longstanding rules in this area and is inconsistent with the purpose of the 340B program. The purpose of the 340B program, in contrast, is to allow providers that treat a significant share of low income individuals to stretch their resources and provide more services to more patients. The purpose of insurer billing rules that include outpatient services with inpatient is to save money for insurers.
- c. Insurance company billing rules do not change the underlying nature of the service or drug provided. A drug given to a registered hospital outpatient is still an outpatient drug regardless of how the insurer requires that it be billed or paid.
- d. Hospitals should be able to use 340B for drugs administered in outpatient settings, regardless of whether the drug is billed as part of an inpatient stay, if the patient was an outpatient at the time the drug was administered or if the drug itself was billed on an outpatient basis.
- e. This proposed policy would impose significant operational challenges:
  - i. EUHM currently utilizes a commercially available accumulation software that tracks inpatient and outpatient dispenses at the time of dispensation (consistent with the current guidance for both 340b eligibility and GPO exclusion). Determination of inpatient or outpatient status is made at the point of dispensation, based on the providers order for level of care. Our commercially available accumulation software would not longer function as designed.
  - ii. Rules about inpatient and outpatient status may differ depending on the payer.
  - iii. Subsequent payer determinations make tracking more challenging and we are frequently finding that we do not finality to patient status for weeks after the initial bill has been submitted to the payor.
  - iv. Unfortunately, payer determinations are more and more frequently not aligning with the provider’s determination about the appropriate patient status or level of care.

#### 5. Bundled Medicaid Drugs

- a. 340B covered entities should be able to use 340B for all Medicaid drugs regardless of whether the drug is bundled into payment made for other services.
- b. The 340B program allows certain hospitals to participate only if the hospitals can demonstrate that they provide a disproportionate amount of care to Medicaid and low-income Medicare patients. It would be inconsistent with the purpose of the program to disallow 340B pricing

for drugs dispensed to that population.

6. **GPO Prohibition - EUHM supports the three exceptions to the GPO prohibition included in the proposed guidance and requests that HRSA clarify the exceptions to allow for additional flexibility.**
  - a. **Proposed New Exceptions:**
    - i. **340B not available:** HRSA should not require hospitals subject to the GPO prohibition to use WAC pricing when 340B pricing is not available, such as when a:
      1. Drug is in shortage
      2. Manufacturer is refusing to offer the 340B price
      3. Manufacturer is not participating in 340B
    - ii. **340B not permitted:** HRSA should not require hospitals subject to the GPO prohibition to use WAC pricing when 340B use is not permitted, such as when a hospital:
      1. Is treating an outpatient who is not eligible to receive a 340B drug (e.g., walk-in patient, ineligible employee)
      2. Carves-out and must provide non-340B drugs to Medicaid patients
      3. Is unable to track a drug appropriately to justify 340B use, such as for intravenous saline solutions, contrast agents, anesthesia gases, and other similar products.
    - iii. HRSA has stated that a purpose behind its GPO prohibition policy is to prevent hospitals from buying covered outpatient drugs through 340B and GPO (i.e., to prevent “cherry picking.”). In these situations, when the 340B price cannot be used, there is no danger of cherry picking. HRSA should therefore allow hospitals to use a GPO in these instances.
  - b. **HRSA should allow hospitals subject to the GPO prohibition to use inventory replenishment systems based on initial GPO purchase and should not require initial purchases to be made through non-340B, non-GPO accounts (i.e. WAC).**
    - i. HRSA should clarify whether HRSA’s February 7, 2013 Policy Release on the Statutory Prohibition on Group Purchasing Organization Participation still applies. In particular, does HRSA still intend to impose the requirement that hospitals subject to the GPO prohibition using virtual replenishment systems “should purchase using a non-GPO account and only replenish with 340B drugs once 340B patient eligibility is confirmed and can be documented through auditable records”? This policy release made clear that hospitals using replenishment models may not first purchase through a GPO and then replenish accordingly.
    - ii. HRSA should allow inventory replenishment systems that make initial purchases at GPO pricing, rather than using non-340B, non-GPO pricing (i.e., WAC).
    - iii. Inventory replenishment is based on the theory that the repurchased drug takes the place of the drug administered or dispensed to the patient. If a GPO drug purchase is “cured” through a subsequent 340B purchase, there is no harm to manufacturers.
    - iv. There are some cases when a hospital is not able to cure a GPO purchase through a 340B replenishment, such as when a drug is in shortage and the drug is not available at 340B for repurchasing or when the package size necessary to make a replacement order is never reached. In these situations, the hospital can cure the GPO use by replenishing at WAC, or some other non-340B, non-GPO price.
    - v. Hospitals should be able to use GPO-based replenishment systems because requiring WAC-based inventory management systems increases hospital costs, inconsistent with the purpose of the 340B program.
7. **Self-Disclosure - Notification to HRSA should only be required for material changes in eligibility and material breaches of program requirements**
  - a. Current HRSA policy requires that covered entities report material noncompliance to HRSA.

The proposed guidance suggests that all such instances must be reported, even if they are not material.

- a. At current, EUHM has a robust and active 340B Governance Committee that reviews monthly audits of compliance. The committee is charged with identifying any corrective actions and determining materiality.
- i. The annual recertification process would require notification of “any 340B Program requirement, subject to HHS audit,” while other sections would require the reporting of “all corrective actions” relating to diversion and discount discounts.
- b. HRSA should limit all disclosures to those that rise to level of being “material.” Notifying HRSA of all program violations, no matter how minor, would be too burdensome for both HRSA and providers, and not provide significant program integrity value.

## 8. Child Site Eligibility

- a. HRSA should permit hospitals to certify that all clinics in an offsite building are 340B-eligible instead of requiring individual registration of each office.
- b. For hospitals that operate in multiple buildings, HRSA should allow a hospital to register one of its hospital buildings as the parent site and register the other buildings as child sites, so long as the hospital could attest that every outpatient clinic/department in the offsite buildings was reimbursable on the hospital’s cost report. Although these offsite hospital buildings may also include inpatient areas that are not 340B-eligible, that should not preclude a hospital from registering the offsite buildings as child sites. HRSA does not require parent hospitals to register 340B-eligible outpatient areas inside the four walls of the parent site, even though parent sites generally include ineligible inpatient areas. The same policy should apply to offsite hospital buildings.
- c. Allowing these certifications would continue to ensure transparency in the registration process and provide manufacturers and other stakeholders with the information necessary to confirm covered entity compliance while making the process simpler for hospitals
- d. **HRSA should allow hospitals to register outpatient facilities without waiting for the facility to file its cost report**
  - i. The proposed guidance includes HRSA’s current policy on outpatient facilities, which requires a hospital registering an outpatient facility as a child site to show that the facility’s costs appear on a reimbursable line of the hospital’s most-recently filed Medicare Cost Report.
  - ii. Relying only on the most-recently filed cost report can cause significant delays to registering child sites. If a hospital opens a new clinic just after the hospital filed its cost report, the hospital must wait another 17 months before filing a new cost report that includes the costs of the new clinic on a reimbursable line and then may potentially have to wait another 6 months before the hospital can register the clinic and have the clinic appear on the OPA database. Meanwhile, Medicare will not require the hospital to wait until it files a new cost report for the clinic to bill for services as part of the hospital.
  - iii. HRSA should accept alternative documentation to show that the clinic is an integral part of the hospital while the hospital waits to file a new cost report. This could include:
    - 1. Medicare 855A enrollment form
    - 2. A certification submitted to HRSA that: (1) the clinic will be listed on a reimbursable line of the cost report when the cost report is filed, (2) the hospital is currently billing for outpatient services at the clinic, and (3) the hospital agrees to repay manufacturers for 340B purchases made for the clinic if the clinic ends up not being billed on a reimbursable line of the cost report once it is filed.

## 9. Contract Pharmacy

- a. HRSA should not expect covered entities to conduct an annual independent audit and

quarterly reviews of each contract pharmacy location.

- i. A covered entity should be able to conduct a single annual independent audit or quarterly review for each contract it has with a contract pharmacy provider, rather than at each site. Typically all of the sites subject to a single agreement use the same processes and software, which is usually maintained at a central location. Requiring covered entities to audit each and every site is an unnecessary drain on resources that provides no added assurances of compliance.
- ii. At current, EUHM conducts monthly audits of contract pharmacy transactions and an annual independent program audit is completed.
- b. **HRSA should not require contract pharmacy agreements to list all child sites that plan to use the contract pharmacy.**
  - i. This requirement would be unnecessarily burdensome.
    - 1. A covered entity would have to amend the contract pharmacy agreement whenever it adds or removes a child site.
    - 2. Nearly all existing contract pharmacy agreements would have to be amended.
    - 3. Very few contract pharmacies serve only a subset of child sites.
  - ii. The requirement would not provide additional transparency concerning a covered entity's use of its contract pharmacy, as an entity does not submit a copy of its contract pharmacy agreement to HRSA when registering a contract pharmacy.

## 10. Audits

- a. HRSA should make the following clarifications to the HRSA audit process of covered entities.
  - i. HRSA should publish its 340B audit protocol.
  - ii. Covered entities should have at least 30 days to respond to a pre-audit data request given the large quantity of data required for submission.
  - iii. HRSA should reinstitute the process of issuing a preliminary audit report. HRSA should communicate preliminary audit findings to covered entities and facilitate an informal dialogue among the auditor, HRSA, and the covered entity so that the covered entity can ask questions about the finding and obtain more detailed information regarding the nature of any adverse findings.
  - iv. Covered entities should have at least 90 days to respond to a final audit report.
  - v. HRSA should commit to creating a mechanism to receive protected health information (PHI) in written disagreements.
  - vi. When a final audit report would result in program termination, the covered entity should be able to request an in-person hearing.
  - vii. HRSA should develop an independent administrative review process between the final audit report and possible judicial action, similar to the administrative law judge (ALJ) process for Medicare audits.
  - viii. If HRSA does not adopt an intermediate review process, HRSA should make clear that the final audit report is final agency action that is ripe for judicial review if the covered entity continues to disagree with HRSA's findings.
  - ix. HRSA proposes to work with covered entities to specify the time frame for the submission of a corrective action plan (CAP), and we appreciate HRSA's willingness to work with covered entities. HRSA should clarify that covered entities have at least 90 calendar days to submit the CAP for HRSA's approval. Covered entities could have more than 90 days, depending on the scope of the audit findings, but never less than 90 days.
- b. **HRSA should make the following clarifications to the manufacturer audit process of covered entities.**
  - i. We are pleased to see that HRSA proposes that a manufacturer must work in good faith with a covered entity to resolve a matter before the manufacturer may submit an audit work plan



to HRSA. We ask that HRSA clarify that in the event that a manufacturer contacts a covered entity to request data from the entity, but is unwilling to disclose the specific reason for the request, then the manufacturer will be in violation of the good faith negotiation requirement.

- ii. HRSA should instruct manufacturers that communications to covered entities reflecting a good faith attempt to resolve differences should include a statement indicating that the communication is not a HRSA-sanctioned manufacturer audit.
- iii. HRSA should allow covered entities at least 60 days to respond to manufacturer data requests.
- c. **We support HRSA's plans to audit manufacturers.**
  - i. We are pleased to see that HRSA has included in the proposed guidance procedures for HRSA to audit manufacturers.
  - ii. We are also pleased that any findings would be made public, as only one audit of a manufacturer has been conducted to date and those results have not yet been made public.
  - iii. HRSA should begin auditing manufacturers on a regular basis to ensure that manufacturers are complying with 340B program requirements so that covered entities may receive the discounts they are entitled to under the program.

#### 11. Inventory Management

- a. HRSA should clarify that improper accumulations that are fixed prior to a replacement order being made do not constitute diversion.
  - i. The preamble states that "if a covered entity improperly accumulates or tallies 340B drug inventory, *even if it is prior to placing an order*, the covered entity has effectively sold or transferred drugs..." (emphasis added).
  - ii. HRSA should clarify that diversion could not occur in a replenishment system until an incorrectly accumulated order is actually placed. Until such time, the accumulation is merely an accounting of what the covered entity may order.

#### 12. Manufacturer Provisions

- a. We support HSRA's recognition of the manufacturer obligation to offer the 340B price and have the following comments.
  - i. The proposed guidance states that manufacturers "subject to a PPA must offer all covered outpatient drugs at no more than the [340B] ceiling price to a covered entity listed on the public 340B database."
  - ii. We appreciate that the proposed guidance reiterates HRSA's view that the "must offer" provision is a requirement for manufacturers who have entered into a PPA, regardless of whether the PPA includes the "must offer" language.
  - iii. The "must offer" provision should apply to specialty drugs that are distributed through limited distribution networks. Some manufacturers have required covered entities to purchase their 340B-priced drugs through a wholesaler's specialty drug division instead of the hospital's usual wholesaler. HRSA should clarify that a manufacturer must allow covered entities to buy a drug through its 340B wholesale account if it would allow the same entity to purchase the drug through a non-340B wholesale account.
  - iv. HRSA should clarify that a manufacturer that offers a covered outpatient drug to any entity must also offer the same drug at 340B pricing to other entities in the same class of trade.
  - v. Some hospitals have faced challenges trying to buy a drug through a contract pharmacy that participates in a limited specialty pharmacy network. The guidance does not clearly address these situations. HRSA should make clear that manufacturers must provide 340B pricing to a covered entity that has a contract pharmacy agreement with a pharmacy in the manufacturer's specialty pharmacy network.
- b. **We support HRSA's proposal to continue its policy of asking manufacturers to notify HRSA**

of limited distribution plans.

- i. The proposed guidance states that HRSA “may” publish the details of limited distribution plans submitted by manufacturers. HRSA should make all limited distribution plans public. It is important that hospitals have access to limited distribution plans in order to assess the impact on the hospital’s operations and to plan accordingly.
- c. **We support HRSA’s proposed requirement for manufactures to issue refunds or credits for instances of overcharging within 90 days and have the following comments.**
  - i. The guidance says that HRSA expects manufacturers to issue refunds or credits for instances of overcharging within 90 days of the determination of the manufacturer or HRSA that an overcharge occurred and that covered entities that fail to accept a refund within 90 days waive their right to repayment. The guidance also states that manufacturers must submit to HHS the price recalculation information, an explanation of why the overcharge occurred, how the refund will be calculated, and to whom refunds or credits will be issued.
  - ii. Covered entities should have 1 year to accept a refund, not 90 days.
    - 1. There have been instances when a refund offer is sent to someone without the power to accept it and it takes time to get it to the correct person. There should also be time given for entities to contest a repayment amount if they do not believe it was calculated correctly.
    - 2. We recommend a one-year period to accept a refund to make sure the repayment is properly received by the covered entity.
  - iii. We support HRSA’s expanded scope of what constitutes an overcharge, which includes errors, intentional overcharges and routine pricing adjustments. We appreciate HRSA recognizing that overcharges can occur due to miscalculation, retroactive readjustments, as well as intentional overcharging.
  - iv. We support HRSA’s interest in knowing how an overcharge occurred. HRSA should expect manufacturers to submit details of overcharging within 30 days of discovery.
  - v. We support HRSA’s proposal that manufacturers may only calculate refunds on an NDC-by-NDC basis, not based on aggregated purchases, *de minimis* amounts, or netting purchases. Refunds on an NDC-by-NDC basis are the fairest way of ensuring that entities receive the correct amount of a refund for each overcharge of a single type of drug.
- d. **We support HRSA’s proposal to conduct an annual recertification process for manufacturers.**
  - i. The proposed guidance says manufacturers should annually review and update their 340B database information as part of a recertification process.
  - ii. We support this proposed process because it will improve database accuracy and enhance program compliance. It is difficult for covered entities to communicate with manufacturers, either to report errors and make repayment or request refunds for overcharges, if manufacturer contact information in the database is not correct.

Many thanks!

Carla

Carla DiBlasio  
Senior Policy Advisor/Legislative Counsel  
Congressman Tom Price, M.D. (GA-06)  
100 Cannon House Office Building  
Washington, DC 20515 | 202.225.4501

**From:** [DiBlasio, Carla](#)  
**To:** [Fitzsimons, Maura \(HHS/ASL\)](#)  
**Subject:** RE: Secretary Burwell response: PFS global procedures proposal  
**Date:** Tuesday, October 18, 2016 8:22:36 PM

---

Thanks so much for the response!

---

**From:** Fitzsimons, Maura (HHS/ASL) [mailto:[Maura.Fitzsimons@hhs.gov](mailto:Maura.Fitzsimons@hhs.gov)]  
**Sent:** Tuesday, October 18, 2016 9:48 AM  
**To:** DiBlasio, Carla  
**Subject:** Secretary Burwell response: PFS global procedures proposal

Hi Carla,

Thank you for Representative Price's letter to Secretary Burwell regarding the CY 2017 Medicare physician fee schedule proposed rule. Attached please find a letter from the Secretary responding to concerns about the global procedure data reporting proposal.

Thanks,  
Maura

**Maura Fitzsimons**

Office of the Assistant Secretary for Legislation  
Department of Health and Human Services  
202.260.7199 | [Maura.Fitzsimons@hhs.gov](mailto:Maura.Fitzsimons@hhs.gov)

**From:** [Fitzsimons, Maura \(HHS/ASL\)](#)  
**To:** [carla.diblasio@mail.house.gov](mailto:carla.diblasio@mail.house.gov)  
**Subject:** Secretary Burwell response: PFS global procedures proposal  
**Date:** Tuesday, October 18, 2016 9:47:00 AM  
**Attachments:** [Price-10-14-16.pdf](#)

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Hi Carla,

Thank you for Representative Price's letter to Secretary Burwell regarding the CY 2017 Medicare physician fee schedule proposed rule. Attached please find a letter from the Secretary responding to concerns about the global procedure data reporting proposal.

Thanks,  
Maura

**Maura Fitzsimons**

Office of the Assistant Secretary for Legislation  
Department of Health and Human Services  
202.260.7199 | [Maura.Fitzsimons@hhs.gov](mailto:Maura.Fitzsimons@hhs.gov)



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

OCT 14 2016

The Honorable Tom Price, M.D.  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding your concerns with the Centers for Medicare & Medicaid Services' (CMS) proposal in the calendar year 2017 Medicare physician fee schedule (PFS) proposed rule for gathering data to use in valuing global procedures under the PFS from all practitioners furnishing such services. I greatly appreciate your bringing these concerns to my attention.

You urged us not to implement the proposal that would require all practitioners furnishing 10 and 90-day global packages to report data on post-operative services and instead to finalize a policy that would only require reporting by a "representative sample" of practitioners. You expressed appreciation that we did not propose to withhold 5-percent of payment until reporting occurred and encouraged us to maintain this provision in the final rule. As you are aware, we made this proposal to comply with section 1848(c)(8), which was added to the Social Security Act by section 523 of the Medicare and CHIP Reauthorization Act, and requires us to collect the data need to value global surgery services.

The comment period on this proposed rule closed on September 7, 2016. In addition to the opportunity to submit comments on the proposed rule, we held a town hall meeting at CMS headquarters. Stakeholders were given the opportunity to make presentations at this meeting, in person or virtually. We are in the process of considering the comments submitted as specified in the proposed rule and developing final regulations, which we expect to issue on or around November 1, 2016.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. If you or your staff have questions, please feel free to contact Jim Esquea, Assistant Secretary for Legislation, at (202) 690-7627. I will also provide this response to co-signers of your letter.

Sincerely,

A handwritten signature in cursive script that reads "Sylvia M. Burwell".

Sylvia M. Burwell

**From:** [Schlichting, Emily \(HHS/ASL\)](#)  
**To:** [Jim.Herz@mail.house.gov](mailto:Jim.Herz@mail.house.gov)  
**Subject:** FY 2015 Agency Financial Report  
**Date:** Monday, November 16, 2015 5:32:00 PM  
**Attachments:** [HHS FY2015 AFR.PDF](#)  
[FY 2015 AFR Letter - Tom Price.pdf](#)

---

Hi Jim,

Attached please find a letter notifying your boss of the FY15 Agency Financial Report for HHS and the full report.

Thanks,  
Emily

Emily Schlichting  
Advisor to the Assistant Secretary for Legislation  
U.S. Department of Health and Human Services  
(202) 690-7414



# Department of Health and Human Services

*Advancing the health, safety,  
and well-being of the nation*



## Fiscal Year 2015 Agency Financial Report





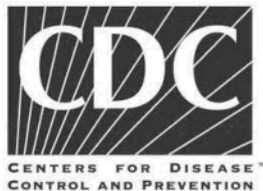
## U.S. Department of Health and Human Services

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ADMINISTRATION FOR  
**CHILDREN & FAMILIES**



**ATSDR**  
AGENCY FOR TOXIC SUBSTANCES  
AND DISEASE REGISTRY



National Institutes  
of Health



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**One Department, One Mission, One HHS!**



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## MESSAGE FROM THE SECRETARY



Sylvia M. Burwell

The mission of the U.S. Department of Health and Human Services (HHS) is to enhance and protect the health and well-being of all Americans. We fulfill that mission by providing effective services and fostering advances in medicine, public health, and social services. We are committed to ensuring that every American has access to the building blocks for healthy and productive lives.

I am pleased to present HHS's Fiscal Year (FY) 2015 Agency Financial Report (AFR). The report highlights our major accomplishments, illustrates how we manage our resources, and outlines our plans to address the challenges we face. At HHS, we are dedicated to meeting the high standards of government reporting and accountability.

### FY 2015 Highlights

HHS administers more than 300 programs that enhance the well-being of others. Four important efforts are highlighted below:

*Access to Health Care.* The Department celebrated two milestone anniversaries this year: the fifth anniversary of the *Affordable Care Act* and the 50th anniversary of Medicare and Medicaid.

Medicare and Medicaid were signed into law by President Johnson in 1965, providing a foundation for health and financial security for our elderly and most vulnerable citizens. Today, 1 in every 3 Americans is covered by Medicare or Medicaid, and they are a lifeline for families across the nation.

The *Affordable Care Act* is expanding access to health coverage to millions of Americans, including many who gained coverage for the first time. A recent analysis shows that since the law passed five years ago, 17.6 million people have gained coverage. The rate of uninsurance in America has dropped to the lowest levels on record.

And the *Affordable Care Act* isn't just about getting insurance. Thanks to new protections, like certain preventive services at no extra cost, everyone's insurance is better, no matter where they buy it. Families across America can now rest a little easier knowing that they can't be dropped just because they get sick or discriminated against if they have a pre-existing condition.

Thanks to the *Affordable Care Act*, community health centers will continue to be a vital source of quality primary care for uninsured and medically underserved patients. Today, there is a national primary care network of more than 1,300 health centers serving nearly 23 million individuals. The *Affordable Care Act* provides additional funding to help new centers reach a projected 1.4 million more Americans to increase access to services such as medical, oral, behavioral, pharmacy, and vision care.

*Behavioral Health.* We are confronting a national opioid abuse crisis. Over the last decade, deaths caused by overdoses of prescription opioid pain relievers and heroin use have increased significantly. The Department is working with state and federal leaders on a coordinated and comprehensive approach to address this crisis. Together, we are focusing on preventing opioid overdose and opioid use disorder, including prescribing practices, increasing access to drugs that reverse opioid overdose, and expanding the use of medication-assisted treatment. Medication-assisted treatment is a comprehensive way to address the needs of individuals that combines the use of medication with counseling and behavioral therapies to treat substance use disorders. HHS will also revise regulations related to prescribing products approved by the Food and Drug Administration for treatment of opioid

dependence. This will increase access to evidence-based treatment, helping more people get the treatment necessary for their recovery.

*Advancing Science and Research.* We recently announced the appointment of nationally recognized experts to the Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria. The council will provide advice, information, and recommendations to HHS on initiatives and policies related to combating antibiotic-resistant bacteria. Antibiotic resistance is a growing public health threat across our country and around the world. The Centers for Disease Control and Prevention has estimated that antibiotic-resistant bacteria are responsible for 2 million infections and 23,000 deaths annually in the U.S.

Work is underway to implement a National Plan for Combating Antibiotic-Resistant Bacteria, a research-driven plan to identify and coordinate action across the Administration to prevent and control outbreaks of resistant pathogens. Detecting, preventing, and controlling antibiotic resistance requires a strategic, coordinated, and global effort. We are working closely with our international partners, recognizing that diseases do not recognize national borders. Together these efforts provide a roadmap to preserve the effectiveness of antibiotics, strengthen surveillance, prevent the transmission of antibiotic-resistant bacteria, further new research, and improve international coordination.

*Leaving the Department Stronger.* Finally, as we look to leave our Department stronger, we are investing in program integrity initiatives that allow us to crack down on waste, fraud and abuse. These initiatives are projected to yield \$22 billion in gross savings for Medicare and Medicaid over the next decade. In 2015, a national fraud takedown led by the Medicare Fraud Strike Force in 17 districts, resulted in charges against 243 individuals for about \$712 million in false billings. In addition, the Department suspended a number of providers using authority provided in the *Affordable Care Act*. This coordinated takedown is the largest in Strike Force history.

### **How We Manage Our Resources**

As responsible stewards of the public resources that the American taxpayers and Congress entrust to us, one of our most important duties is to practice fiscal responsibility and transparency. To that end, our Department-wide financial statement audit is one of our most important tools. This year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2015 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. The “Financial Section” of this report includes more detailed information.

As required by the *Federal Managers’ Financial Integrity Act of 1982* (FMFIA) and the Office of Management and Budget’s Circular A-123, *Management’s Responsibility for Internal Control*, we also evaluated our internal controls and financial management systems. We identified one material weakness, which also constitutes a non-conformance under Section 4 of FMFIA relating to Information System Controls and Security. We also identified one material noncompliance relating to Error Rate Measurement. Management continues efforts to improve our financial reports and systems. The “Management’s Discussion and Analysis” section of this report includes further details. Based on our internal assessments and the auditor’s report, I believe that our financial and performance data are reliable and complete.

**Future Challenges**

Despite our successes, HHS still faces challenges and opportunities for improvement. We have worked closely with the Office of Inspector General to gain its perspective about our most significant management and performance challenges, which are presented in the “Other Information” section under *FY 2015 Top Management and Performance Challenges Identified by the Office of Inspector General*. The HHS Inspector General identified 10 performance challenges that present opportunities for improvement. These challenges include overseeing the Health Insurance Marketplace, safeguarding privacy and data security, and protecting HHS grants and contract funds from fraud, waste, and abuse.

**Looking Ahead**

We look forward to continuing our work to protect the health and well-being of the American people in the coming years. We will build and strengthen relationships with anyone and everyone who shares our passion for impact and progress while helping Americans obtain the building blocks for healthy and productive lives.

/Sylvia M. Burwell/

Sylvia M. Burwell  
Secretary  
November 13, 2015

## ABOUT THE AGENCY FINANCIAL REPORT

The HHS FY 2015 AFR provides fiscal and summary performance results that enable the President, Congress, and the American people to assess our accomplishments for the reporting period October 1, 2014 through September 30, 2015. This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We have prepared this report in accordance with the requirements of the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements*. This document consists of three primary sections and appendices:



### Management's Discussion and Analysis

The Management's Discussion and Analysis (MD&A) section provides an overview of the entire report. Specifically, the MD&A presents an overview of performance and financial highlights for FY 2015. It also discusses HHS's compliance with legal and regulatory requirements, a summary of audit and management assurances, and gives a brief look ahead to FY 2016.



### Financial Section

The Financial Section includes the Report of the Independent Auditors, the Department's Principal Financial Statements, Notes to the Principal Financial Statements, Required Supplementary Stewardship Information, and Required Supplementary Information.



### Other Information

The Other Information section contains additional financial information including the Schedule of Spending, the Improper Payments Information Act Report, and the Office of Inspector General's FY 2015 assessment of management challenges facing the Department.



### Appendices

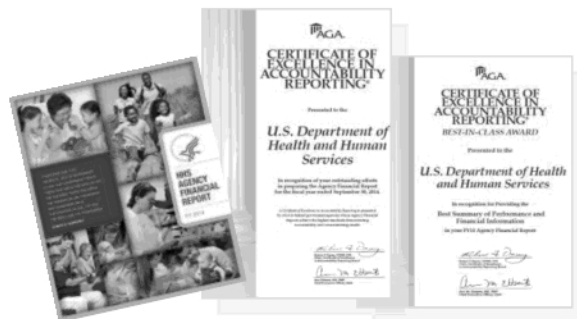
The appendices include data that supports the main sections of the AFR. This includes a glossary of acronyms used in the report and resources for connecting with the Department.

The Department has chosen to produce an AFR and *Annual Performance Plan and Report*. In February 2016, additional reports that will be available on HHS/About HHS/Budget & Performance ([www.hhs.gov/budget](http://www.hhs.gov/budget)) include:

1. FY 2015 *HHS Summary of Performance and Financial Information*
2. FY 2017 *Annual Performance Plan and Report*
3. FY 2017 *Congressional Budget Justification*

## Certificate of Excellence in Accountability Reporting

In May 2015, HHS received the Certificate of Excellence in Accountability Reporting (CEAR) from the Association of Government Accountants (AGA) for its FY 2014 AFR. The CEAR Program was established by the AGA, in conjunction with the Chief Financial Officers Council, to further performance and accountability reporting. FY 2014 marks the second year the Department received this prestigious award. AGA also presented HHS with a Best in Class Award for its Summary of Performance and Financial Information.





# Management's Discussion and Analysis



## *About the photo*

*Secretary Burwell reading to children during a visit to the Nia Family Center (Head Start).*

## In This Section

- About the Department of Health and Human Services
- Performance Goals, Objectives, and Results
- Systems, Legal Compliance, and Internal Control
- Management Assurances
- Looking Ahead to FY 2016
- Analysis of Financial Statements and Stewardship Information

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## ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department of Health and Human Services (HHS or the Department) is the United States (U.S.) government's principal agency for protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. HHS represents almost a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than one billion claims per year. Medicare and Medicaid together provide health care insurance for 1 in 3 Americans.

### ***Mission Statement***

*Our mission is to enhance the health and well-being of Americans by providing for effective health and human services, and by fostering sound, sustained advances in the sciences, underlying medicine, public health, and social services.*

HHS works closely with state and local governments and many HHS-funded services are provided at the local level by state or county agencies, or through private sector grantees. The HHS Office of the Secretary (OS) and its 11 Operating Divisions (OpDivs) administer more than 300 programs, covering a wide spectrum of activities. In addition to the services they deliver, HHS programs provide for equitable treatment of beneficiaries nationwide and enable the collection of national health and other data.

**Our vision** is to provide the building blocks that Americans need to live healthy, successful lives. Each HHS OpDiv contributes to our mission and vision as follows:

**The Administration for Children and Families (ACF)** is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF programs aim to empower families and individuals to increase their economic independence and productivity, and encourage strong, healthy, supportive communities that have a positive impact on quality of life and the development of children. For more information, refer to [www.acf.hhs.gov](http://www.acf.hhs.gov).

**The Administration for Community Living (ACL)** is the single agency charged to work with states, localities, tribal organizations, nonprofit organizations, businesses, and families to help older adults and people with disabilities live independently and fully participate in their communities. ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. For more information, refer to [www.acl.gov](http://www.acl.gov).



A teacher reads to children in a West Virginia Head Start program.

**The Agency for Healthcare Research and Quality's (AHRQ)** mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within HHS and with other partners to make sure that the evidence is understood and used. This mission is supported by focusing on (1) improving health care quality, (2) making health care safer, (3) increasing accessibility, and (4) improving health care affordability, efficiency, and cost transparency. For more information, refer to [www.ahrq.gov](http://www.ahrq.gov).

**The Agency for Toxic Substances and Disease Registry (ATSDR)** is charged with the prevention of exposure to toxic substances and the prevention of the adverse health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment. For more information, refer to [www.atsdr.cdc.gov](http://www.atsdr.cdc.gov).

**The Centers for Disease Control and Prevention (CDC)** collaborates to create the expertise, information, and tools that people and communities need to protect their health through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. CDC works to protect America from health, safety, and security threats, both foreign and domestic. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same. For more information, refer to [www.cdc.gov](http://www.cdc.gov).

**The Centers for Medicare & Medicaid Services (CMS)** administers public insurance programs that serve as the primary sources of health care coverage for seniors and a large population of medically vulnerable individuals. CMS acts as a catalyst for enormous changes in the availability and quality of health care for all Americans. In addition to these programs, CMS has the responsibility to ensure effective, up-to-date health care coverage, and to promote quality care for beneficiaries. CMS is also responsible for helping to implement many provisions of the *Patient Protection and Affordable Care Act (Affordable Care Act)*, such as the establishment of the Federally Facilitated Marketplace (FFM). For more information, refer to [www.cms.gov](http://www.cms.gov).

**The Food and Drug Administration (FDA)** is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation.

FDA is also responsible for advancing the public health by helping to speed innovations that make medicines more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medicines and foods to maintain and improve their health. FDA also has responsibility for regulating the manufacturing, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors.



Finally, FDA plays a significant role in the nation's counterterrorism capability. FDA fulfills this responsibility by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats. For more information, refer to [www.fda.gov](http://www.fda.gov).

**The Health Resources and Services Administration (HRSA)** is responsible for improving access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. HRSA's programs provide health care to people who are geographically isolated, and economically, or medically vulnerable. For more information, refer to [www.hrsa.gov](http://www.hrsa.gov).

**The Indian Health Service (IHS)** is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. IHS is the principal federal health care provider and health advocate for the Indian people, with the goal of raising Indian health status to the highest possible level. IHS provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives who belong to 566 federally recognized tribes in 35 states. For more information, refer to [www.ihs.gov](http://www.ihs.gov).

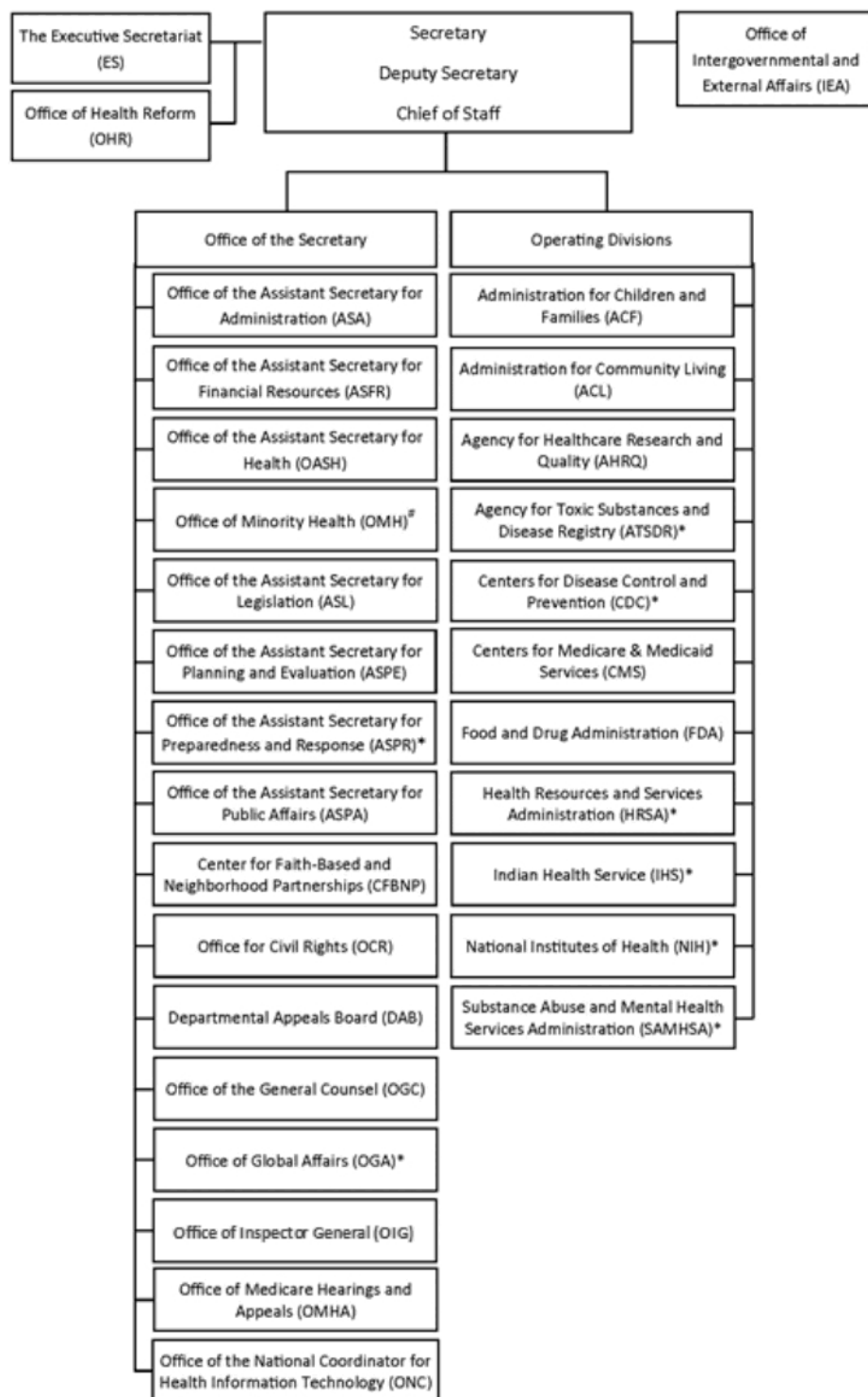
**The National Institutes of Health (NIH)** seeks fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. For more information, refer to [www.nih.gov](http://www.nih.gov).

**The Substance Abuse and Mental Health Services Administration (SAMHSA)** is responsible for reducing the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards, and improving behavioral health practice in communities, in both primary and specialty care settings. For more information, refer to [www.samhsa.gov](http://www.samhsa.gov).

**The Office of the Secretary (OS)**, with the Secretary, leads HHS and its 11 OpDivs to provide a wide range of services and benefits to the American people. In addition, the following Staff Divisions (StaffDivs) report directly to the Secretary, managing programs and supporting the OpDivs in carrying out our mission. The StaffDivs are:

- Immediate Office of the Secretary (IOS) [www.hhs.gov/about/agencies/staff-divisions/immediate-office-secretary/index.html](http://www.hhs.gov/about/agencies/staff-divisions/immediate-office-secretary/index.html)
  - The Executive Secretariat (ES)
  - Office of Health Reform (OHR)
  - Office of Intergovernmental and External Affairs (IEA) [www.hhs.gov/intergovernmental](http://www.hhs.gov/intergovernmental)
- Office of the Assistant Secretary for Administration (ASA) [www.hhs.gov/asa](http://www.hhs.gov/asa)
  - Program Support Center (PSC) [www.hhs.gov/asa/psc](http://www.hhs.gov/asa/psc)
- Office of the Assistant Secretary for Financial Resources (ASFR) [www.hhs.gov/asfr](http://www.hhs.gov/asfr)
- Office of the Assistant Secretary for Health (OASH) [www.hhs.gov/ash](http://www.hhs.gov/ash)
- Office of Minority Health (OMH) [www.minorityhealth.hhs.gov](http://www.minorityhealth.hhs.gov)
- Office of the Assistant Secretary for Legislation (ASL) [www.hhs.gov/asl](http://www.hhs.gov/asl)
- Office of the Assistant Secretary for Planning and Evaluation (ASPE) [www.aspe.hhs.gov](http://www.aspe.hhs.gov)
- Office of the Assistant Secretary for Preparedness and Response (ASPR) [www.phe.gov/preparedness](http://www.phe.gov/preparedness)
- Office of the Assistant Secretary for Public Affairs (ASPA) [www.hhs.gov/aspa](http://www.hhs.gov/aspa)
- Center for Faith-Based and Neighborhood Partnerships (CFBNP) [www.hhs.gov/partnerships](http://www.hhs.gov/partnerships)
- Office for Civil Rights (OCR) [www.hhs.gov/ocr](http://www.hhs.gov/ocr)
- Departmental Appeals Board (DAB) [www.hhs.gov/dab](http://www.hhs.gov/dab)
- Office of the General Counsel (OGC) [www.hhs.gov/ogc](http://www.hhs.gov/ogc)
- Office of Global Affairs (OGA) [www.globalhealth.gov](http://www.globalhealth.gov)
- Office of Inspector General (OIG) [www.oig.hhs.gov](http://www.oig.hhs.gov)
- Office of Medicare Hearings and Appeals (OMHA) [www.hhs.gov/omha](http://www.hhs.gov/omha)
- Office of the National Coordinator for Health Information Technology (ONC) [www.healthit.gov/newsroom/about-onc](http://www.healthit.gov/newsroom/about-onc)

Below, we present the HHS organizational chart, which consists of the OS ([www.hhs.gov/secretary](http://www.hhs.gov/secretary)), and the noted StaffDivs and OpDivs. For further information regarding our organization, components, and programs, visit our website at [www.hhs.gov/about/foa](http://www.hhs.gov/about/foa).



\*Components of the Public Health Service

#Administratively-supported by OASH

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

### Overview of Strategic and Agency Priority Goals

Every four years HHS updates its strategic plan, which describes its work to address complex, multifaceted, and evolving health and human services issues. An agency strategic plan is 1 of 3 main elements required by the *Government Performance and Results Act of 1993* (GPRA) and the *GPRA Modernization Act of 2010*. The Department's Strategic Plan (Plan) defines its mission, goals, and the means by which it will measure its progress in addressing specific national problems over a four-year period. In addition, each of the Department's OpDivs and StaffDivs contribute to the development of the strategic plan, as reflected in the Plan's strategic goals, objectives, strategies, and performance goals.

The HHS Strategic Plan FY 2014 – 2018 describes the Department's efforts within the context of broad strategic goals. This Plan identifies four strategic goals and 21 related objectives. The four strategic goals are:

Goal 1: Strengthen Health Care


Goal 2: Advance Scientific Knowledge and Innovation

Goal 3: Advance the Health, Safety, and Well-being of the American People

Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

The strategic goals and associated objectives focus on the major functions of HHS. Although the strategic goals and objectives in the Plan are presented as separate sections, they are interrelated, and successful achievement of one strategic goal or objective can influence the success of others. For example, the application of a promising new scientific discovery (Strategic Goal 2) can affect the quality of health care patients receive (Strategic Goal 1) and/or the success of human service programs (Strategic Goal 3). Improving economic well-being and other social determinants of health (Strategic Goal 3) can improve health outcomes (Strategic Goal 1). Responsible management and stewardship of federal resources (Strategic Goal 4) can create efficiencies the Department can leverage to advance its health, public health, research, and human services goals. For the second consecutive year, HHS conducted an annual Strategic Review, which consisted of various senior Department leaders reviewing performance data, evidence, and other factors for the 21 objectives. The annual review allows HHS leadership to undertake a high-level look at results, challenges, and future initiatives across the Department.

Following is a summary of the strategic goals and objectives established in the FY 2014 – 2018 Plan.



CDC participants  
in one of 585  
emergency  
response  
training events.

**Strategic Goal 1**  
**Strengthen Health Care**

Objectives

- Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured
- Improve health care quality and patient safety
- Emphasize primary and preventive care, linked with community prevention services
- Reduce the growth of health care costs while promoting high-value, effective care
- Ensure access to quality, culturally competent care, including long-term services and support for vulnerable populations
- Improve health care and population health through meaningful use of health information technology

**Strategic Goal 2**  
**Advance Scientific Knowledge and Innovation**

Objectives

- Accelerate the process of scientific discovery to improve health
- Foster and apply innovative solutions to health, public health, and human services challenges
- Advance the regulatory sciences to enhance food safety, improve medical product development, and support tobacco regulation
- Increase our understanding of what works in public health and human services practice
- Improve laboratory, surveillance, and epidemiology capacity

**Strategic Goal 3**  
**Advance the Health, Safety, and Well-being of the American People**

Objectives

- Promote the safety, well-being, resilience, and healthy development of children and youth
- Promote economic and social well-being for individuals, families, and communities
- Improve the accessibility and quality of supportive services for people with disabilities and older adults
- Promote prevention and wellness across the life span
- Reduce the occurrence of infectious diseases
- Protect Americans' health and safety during emergencies, and foster resilience to withstand and respond to emergencies

**Strategic Goal 4**  
**Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs**

Objectives

- Strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud, and integrating financial, performance, and risk management
- Enhance access to and use of data to improve HHS programs and to support improvements in the health and well-being of the American people
- Invest in the HHS workforce to help meet America's health and human services needs
- Improve HHS environmental, energy, and economic performance to promote sustainability

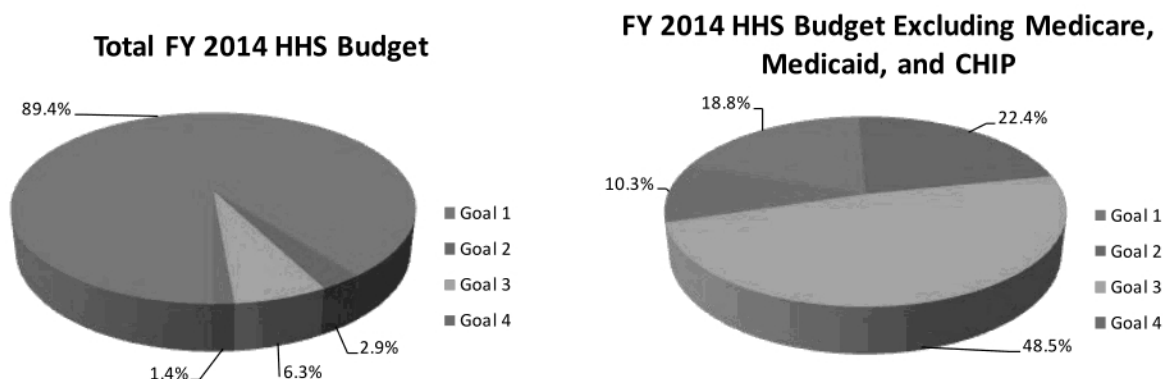


## Looking Back at FY 2014 Performance and Budget

It is helpful to look at how HHS invests resources toward fulfilling the Department's mission through its strategic goals. Below are two charts that show the proportion of financial resources that are primarily dedicated to achieving each strategic goal.

Although HHS funding here is broken down into strategic goals, many of the programs in HHS are crosscutting in nature and support a number of strategic goals. The chart on the left provides the breakdown of the HHS budget by strategic goal. The majority of the Department's funding was primarily associated with Goal 1 because of the large amount of money invested in delivering quality care and services through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). For FY 2014, of the four strategic goals, 89.4 percent was spent on Goal 1, 2.9 percent on Goal 2, 6.3 percent on Goal 3, and 1.4 percent on Goal 4.

The chart on the right illustrates the HHS budget excluding the costs of Medicare, Medicaid, and CHIP. Of the four strategic goals excluding Medicare, Medicaid, and CHIP, 18.8 percent was spent on Goal 1, 22.4 percent on Goal 2, 48.5 percent on Goal 3, and 10.3 percent on Goal 4.



Similar information on resource allocation for FY 2015 strategic goals will be published in the FY 2015 *HHS Summary of Performance and Financial Information*, available in February 2016 on HHS/About HHS/Budget & Performance ([www.hhs.gov/budget](http://www.hhs.gov/budget)). A detailed breakdown of FY 2015 spending by HHS activity and budget function is available in the "Other Information" section of this report.

## Performance Management

HHS uses Agency Priority Goals (APGs), also referred to as HHS Priority Goals, to improve performance and accountability. HHS developed APGs by collaborating across the Department to identify activities that would reflect HHS priorities. We utilized the knowledge we gained through collaboration and during data-driven reviews to develop our APGs. These goals are a set of ambitious, but realistic performance objectives that the Department will strive to achieve within a 24-month period. APGs are a limited number of specific performance targets that advance progress toward longer-term outcomes. HHS is currently engaged in five APGs for FY 2014 – FY 2015 that will support the achievement of our strategic goals:

- Improve Patient Safety
- Improve Health Care Through Meaningful Use of Health Information Technology
- Improve the Quality of Early Childhood Education
- Reduce Combustible Tobacco Use
- Reduce Foodborne Illness in the Population

HHS performance initiatives, including APGs, continue to influence plans and policies as demonstrated in the Department's Plan, which guides our efforts into the future.



Secretary Burwell attends G7 Health Ministers Meeting in Germany to discuss strategies and best practices in disease prevention and treatment.

HHS continues to engage with individuals across the federal performance management community to implement best practices and refine our processes. These refinements and lessons learned have also influenced future plans and priorities. Refer to the "Looking Ahead to 2016" section for further details. HHS will actively monitor progress and work towards achieving our goals through quarterly data-driven reviews and other mechanisms. The most recent data, accomplishments, and future actions on HHS APGs, as well as information on previous APG cycles, can be found on [www.performance.gov](http://www.performance.gov). The website provides information on the measures and milestones used by HHS to monitor progress toward these goals.

In addition to the APGs and strategic reviews, HHS reported data on 137 key performance measures in its FY 2015 *HHS Annual Performance Plan and Report*. These measures represent important issue areas being addressed by the health care and human services communities. The performance measures present a powerful tool to improve HHS operations and help to advance an effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions. While HHS does not yet have FY 2015 data available for all measures due to the lag associated with data collection and reporting, HHS's OpDivs and StaffDivs constantly strive to find lower-cost ways to achieve positive impacts in addition to sustaining and fostering the replication of effective and efficient government programs. For more information on results from FY 2015 and earlier, consult the *HHS Annual Performance Plan and Report*, released annually in February along with the President's Budget.

## Performance Results

The performance results in this section represent key measures and performance highlights demonstrating progress toward each HHS strategic goal.

The accomplishments and performance trends, including progress on HHS Priority Goals, underscore HHS's dedication to sustained performance improvement, and emphasis on working to meet the Department's four strategic goals. Targets presented within the graphs represent performance expectations based on a number of factors and may not exceed the previous years' results, although they may represent an improvement over previous years' targets. The results marked with an asterisk (\*) within each strategic goal indicate targets that were met or exceeded for the applicable period. Some results were not available at the time of this report due to the lag associated with data collection requirements. The target is displayed to show planned progress. In February 2016, additional performance measures and trends will be available in related reports on HHS/About HHS/Budget & Performance ([www.hhs.gov/budget](http://www.hhs.gov/budget)).



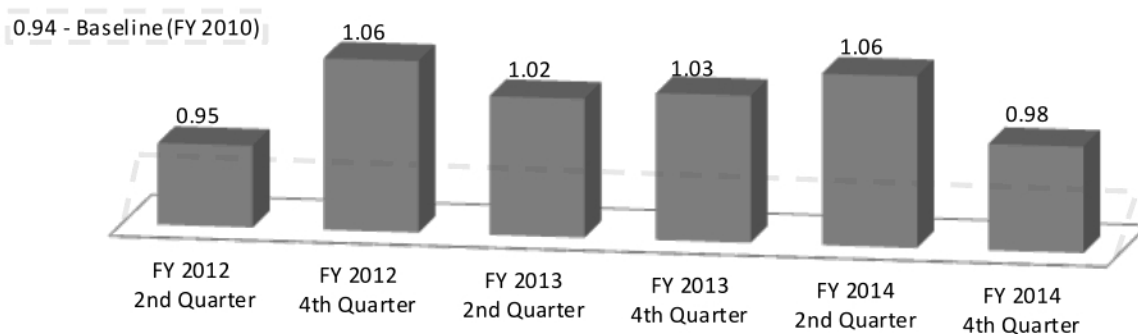
## Strategic Goal One: Strengthen Health Care

On March 23, 2010, President Obama signed the *Affordable Care Act* into law, transforming and modernizing the American health care system. HHS continues to drive the effort to strengthen and modernize health care to improve patient outcomes. Through its programs, HHS also promotes efficiency and accountability, ensures patient safety, encourages shared responsibility, and works toward high-value health care. In addition to addressing these responsibilities, HHS is improving access to culturally competent, quality health care for uninsured, underserved, and vulnerable populations.

**Standardized Infection Ratio of Catheter-Associated Urinary Tract Infections.** HHS's efforts to reduce Healthcare-Associated Infections (HAIs), which would improve patient safety and health care quality, are reflected in the "Improve Patient Safety" APG ([www.performance.gov/content/improve-patient-safety](http://www.performance.gov/content/improve-patient-safety)). These infections can lead to significant morbidity and mortality, with tens of thousands of lives lost each year. During the FY 2014 – FY 2015 APG period, HHS efforts focused on catheter-associated urinary tract infections (CAUTI).

Leveraging the combined programmatic efforts within HHS, including AHRQ, CDC, CMS, and OASH, the "Improve Patient Safety" APG is working to reduce CAUTI by 10 percent in hospitals nationwide by the end of FY 2015. This is measured over the FY 2013 Standardized Infection Ratio (SIR) of 1.03. The most current National Healthcare Safety Network (NHSN) data for the time period through September 30, 2014 shows a CAUTI SIR of 0.98. This is a reduction from the previous cycle's CAUTI SIR of 1.06. Knowledge gained during this period has led to better data tracking and monitoring as well as new approaches in the Intensive Care Units (ICUs) based on identified potential barriers. Analysis of the CAUTI data continues to reveal marked difference in reductions between ICUs and non-ICUs. ICUs have significantly higher SIRs, higher number of catheter-days, and show less reductions in these indicators of progress than in the non-ICU setting. Lessons learned were also used to focus HHS efforts, including targeting the hospitals with the highest excess number of CAUTIs. HHS program efforts that help health care partners achieve this goal include AHRQ's Comprehensive Unit-based Safety Program (CUSP), CDC's development and maintenance of the NHSN, CMS's Quality Improvement Organizations and Partnership for Patients initiative, and strategic direction and support from OASH, including the National Action Plan to Prevent HAIs.

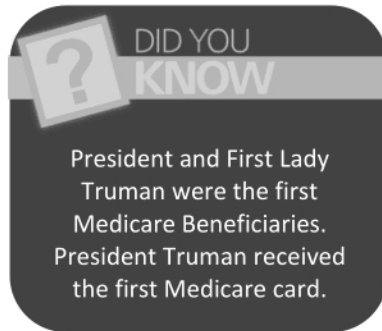
**APG - Improve Patient Safety**  
*Standardized Infection Ratio of Catheter-Associated Urinary Tract Infections*  
 (\* result met or exceeded target)<sup>1</sup>



<sup>1</sup> The reporting frequency for this measure is semi-annually. A new CAUTI definition went into effect in January 2015; therefore, this chart only presents results and baseline data prior to January 2015. Outstanding data and a new baseline are expected in March 2016.

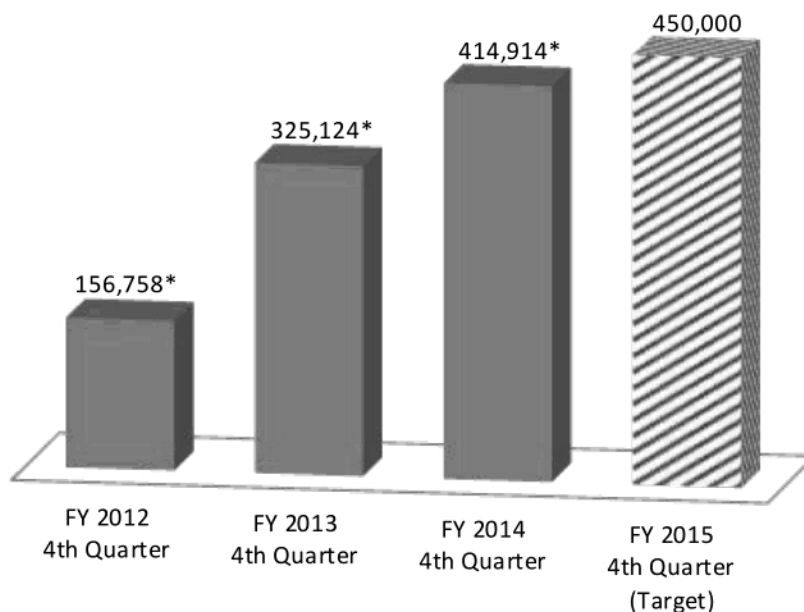
### Incentive Payments from CMS Medicare and Medicaid Electronic Health Records Incentive Programs.

At the heart of HHS's strategy to strengthen and modernize health care is the use of data to improve health care quality, reduce unnecessary health care costs, decrease paperwork, expand access to affordable care, improve population health, and support reformed payment structures. The nation's health information technology infrastructure enables the flow of information to power these critical efforts that can help facilitate the types of fundamental changes in access and health care delivery set forth in the *American Recovery and Reinvestment Act of 2009*. A key step in this strategy is to provide incentive payments to eligible providers serving Medicare and Medicaid beneficiaries who adopt and meaningfully use certified electronic health records (EHR) technology. The "Improvement of Health Care through Meaningful Use of Health Information Technology" ([www.performance.gov/content/improve-health-care-through-meaningful-use-health-information-technology](http://www.performance.gov/content/improve-health-care-through-meaningful-use-health-information-technology)) continued as an APG for the FY 2014 – FY 2015 period, with a goal of 450,000 incentive payments by the end of 2015. As of the third quarter of 2015, this goal has already been surpassed, with 471,516 incentive payments made. Note that while information is collected quarterly, targets are generally set annually.



#### APG – Improve Health Care through Meaningful Use of Health Information Technology

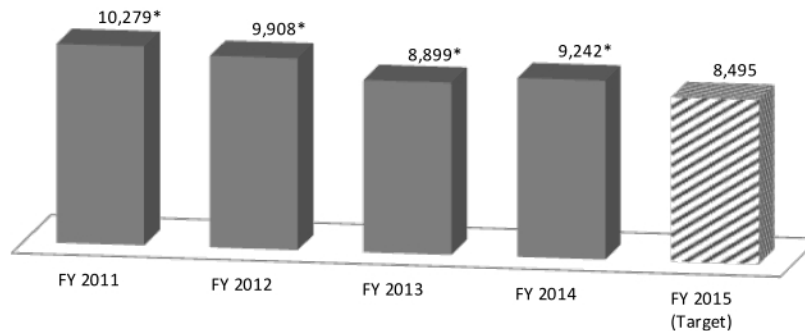
Number of Eligible Providers who Receive an Incentive Payment from  
CMS Medicare and Medicaid Electronic Health Records Incentive Programs  
(\* result met or exceeded target)<sup>2</sup>



<sup>2</sup> Data results were not available at the time of publication. Results should be available in the FY 2017 Annual Performance Plan and Report published in February 2016.

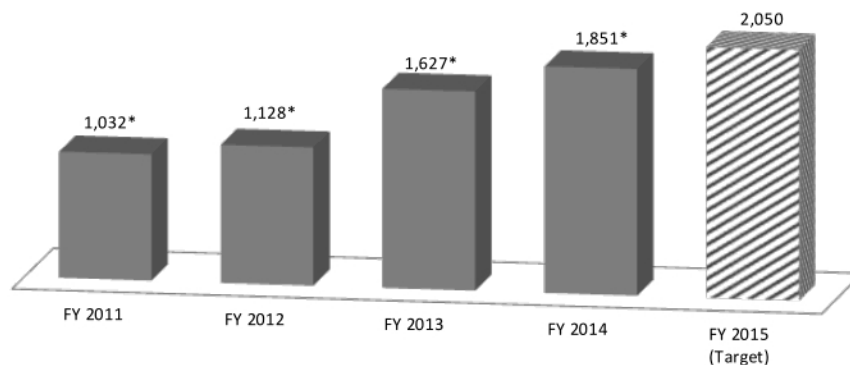
**Field Strength of the National Health Service Corps.** The National Health Service Corps (NHSC) addresses the nationwide shortage of health care providers by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. More than 45,000 primary care medical, dental, mental, and behavioral health professionals have served in the NHSC since its inception. The field strength indicates the number of providers fulfilling active service obligations with the NHSC in underserved areas in exchange for scholarship or loan repayment support. In FY 2014, the NHSC field strength was 9,242, exceeding the target of 7,522. The annual field strength is dependent upon funding levels and programmatic policy decisions that allocate funding between the scholarship and loan repayment programs. NHSC loan repayors are immediately counted in the annual field strength, while NHSC scholars are not counted until completion of training. Future designated mandatory funding will further bolster the NHSC field strength to expand access to primary care services in underserved communities and vulnerable populations in high need urban and rural communities across the country.

*Field Strength of the NHSC, as Measured by the Number of Providers Fulfilling Active Service Obligations in Exchange for Scholarship and Loan Repayment Agreements*  
(\* result met or exceeded target)<sup>2</sup>



**Users of AHRQ-Supported Research Tools.** As an indicator of the number of health care organizations using AHRQ-supported tools to improve patient safety, AHRQ relies in part on the Hospital Survey of Patient Safety (HSOPS). Some organizations that use the survey voluntarily submit their data to a comparative database for aggregation. In FY 2014, 1,851 hospitals indicated in this survey that they use AHRQ-supported tools to improve patient safety, exceeding the target as the program has consistently for years. Interest in other AHRQ tools and resources has also remained strong, as evidenced by on-going participation in informational webinars, electronic downloads, and orders placed for various products.

*Number of Users of Research Using AHRQ-Supported Research Tools to Improve Patient Safety Culture*  
(\* result met or exceeded target)<sup>2</sup>



<sup>2</sup> Data results were not available at the time of publication. Results should be available in the FY 2017 Annual Performance Plan and Report published in February 2016.

**Accountable Care Organizations (ACOs)** are groups of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated high quality care to Medicare patients. This coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. Leveraging the innovative model of ACOs is a key part of promoting health care cost savings through the *Affordable Care Act*. As part of the delivery system reform process, we aim to increase the number of Medicare beneficiaries who aligned with the ACOs and the number of physicians participating in the ACOs. While data collection on a number of ACO-related measures began only in 2013, early results are encouraging. In calendar year 2013, the baseline year, over 4 million Medicare beneficiaries aligned to ACOs, with the expectation of increasing alignment to more than 7 million beneficiaries during the 2015 calendar year. The number of physicians participating in an ACO in FY 2013 was 102,717. For the 2015 calendar year, we expect physician participation to increase by almost 80 percent to 178,000 physicians. Data results for 2014 were not available at the time of publication. Results should be available in the FY 2017 *HHS Annual Performance Plan and Report* published in February 2016.

## Strategic Goal Two: Advance Scientific Knowledge and Innovation

HHS is expanding its scientific understanding of how best to advance health care, public health, human services, and biomedical research and to ensure the availability of safe medical and food products. Chief among these efforts is the identification, implementation, and rigorous evaluation of new approaches in science, health care, public health, and human services. These efforts encourage efficiency, effectiveness, sustainability, and sharing or translating that knowledge into better products and services.

In FY 2014, electronic media reach of the *CDC Vital Signs* monthly report was over 3.5 million potential viewings, exceeding its year-end target goal of 2.9 million potential viewings. During FY 2014, CDC published over 240 Morbidity and Mortality Weekly Report (MMWR) publications, and increased total electronic media reach by 23 percent since FY 2012 from 18.1 million to 22.2 million during FY 2014. In FY 2015, CDC expects an increase in electronic media reach of *CDC Vital Signs* and MMWR weekly and serial publications.



Since 2013, SAMHSA has leveraged mobile technology to increase the reach of its resources by launching multiple mobile applications (apps). Each new app has had a greater reach than the ones that preceded it. First, to further support behavioral health first responders, SAMHSA developed and launched the behavioral health disaster mobile app that allows behavioral health first responders to zero in on the exact location to respond to a disaster and easily access and share behavioral health resources, updated in real-time, for those most in need at a disaster site. In August of 2014, SAMHSA released "KnowBullying." "KnowBullying" empowers parents,

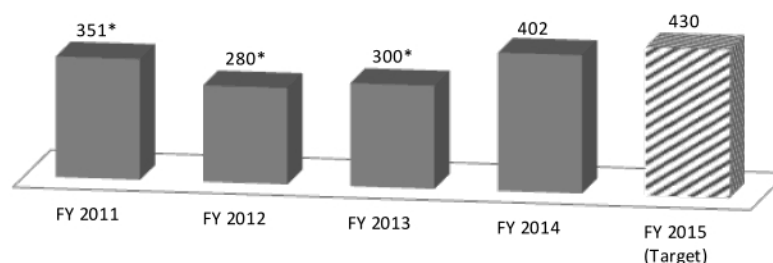
caregivers, and educators with the tools they need to start a conversation about bullying with their children. "KnowBullying," a 2014 recipient of the Bronze Award in the Mobile category from the Web Health Awards, describes strategies to prevent bullying and explains how to recognize warning signs that a child is bullying, witnessing bullying, or being bullied. Then, in February of 2015, SAMHSA launched the "Suicide Safe" app for primary care and behavioral health providers. This app is designed to help providers address suicide risk and integrate suicide prevention strategies in patient care. "Suicide Safe" has been downloaded over 23,500 times since its launch, and received the 2015 Silver Digital Health Information Award. In the future, SAMHSA will continue to innovate in these new platforms by launching additional mobile apps to address other important behavioral health topics.

Individuals who have experienced a traumatic brain injury (TBI) are more likely to experience ongoing neurological and psychological symptoms. Currently, there is no way to identify those who are at greatest risk for developing these chronic symptoms. However, recent NIH research suggests that a protein known as tau may be responsible for the long-term complications from TBI. Using a new, ultra-sensitive technology, a team of researchers led by the NIH was able to measure levels of tau in the blood months and years after military personnel had experienced TBI. Elevated levels of tau are associated with chronic neurological symptoms, including post-concussive disorder, during which an individual has symptoms such as headache and dizziness in the weeks and months after injury. These chronic neurological symptoms have been linked to progressive brain degeneration that leads to dementia following repetitive TBIs, independent of other factors such as depression and post-traumatic stress disorder. With further study, these findings may provide a framework for identifying patients who are most at risk for experiencing chronic symptoms related to TBI. Knowledge of the relationship of tau accumulation to chronic complications related to TBI may also someday provide a therapeutic target for treating the causes of neurodegenerative and psychological conditions that can result from these types of injury.



**International Field Epidemiology Training Programs.** Since 1980, CDC has developed International Field Epidemiology Training Programs (FETP) serving 60 countries that have graduated over 3,600 epidemiologists. Through FETPs, CDC helps establish a network of disease detectives around the globe that are the first line of defense in detecting and responding to outbreaks in their respective countries as well as neighboring countries. From the most current data available in FY 2014, FETP graduates and residents led 424 outbreak investigations, and CDC's Global Disease Detection Centers responded to 319 disease outbreaks. On average, over 80 percent of FETP graduates work within their Ministry of Health after graduation and many assume key leadership positions, such as the National Director of Tuberculosis program and National Director of Chronic Disease program in the Dominican Republic. Although short of its target of 430 new residents, CDC brought on more new FETP residents in FY 2014 than in any previous year, strengthening global health ministries' ability to detect and respond to outbreaks.

*Capacity of Epidemiology and Laboratory within Global Health Ministries through FETP  
as measured by the Number of New Residents  
(\* result met or exceeded target)<sup>2</sup>*



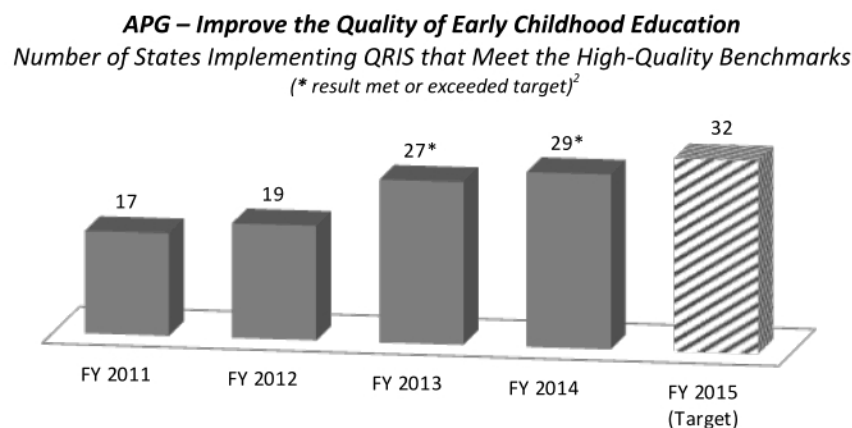
### Strategic Goal Three: Advance the Health, Safety, and Well-Being of the American People

HHS strives to promote the health, economic, and social well-being of children, people with disabilities, and older adults while improving wellness for all. To meet this goal, the Department is employing evidence-based strategies

<sup>2</sup> Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

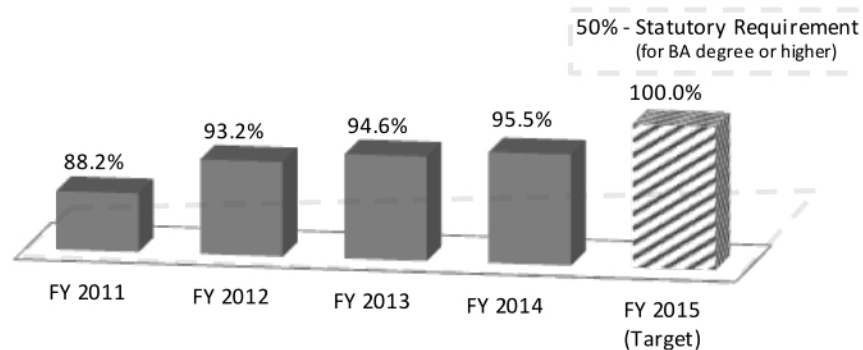
to strengthen families and to improve outcomes for children, adults, and communities. A focus on prevention underlies each objective and strategy associated with this goal.

**Quality Rating and Improvement Systems with High-Quality Benchmarks.** The “Improve the Quality of Early Childhood Education” APG ([www.performance.gov/content/improve-quality-early-childhood-education](http://www.performance.gov/content/improve-quality-early-childhood-education)) calls for actions to improve the quality of programs for children of low-income families, namely Head Start and Child Care. For the Child Care program, the aim is to increase the number of states with Quality Rating and Improvement Systems (QRIS) that meet the seven high-quality benchmarks for child care and other early childhood programs developed by HHS. QRIS is a mechanism used to improve the quality of child care available in communities and to increase parents’ knowledge and understanding of available child care options. Through FY 2014, 29 states had a QRIS that met high-quality benchmarks, meeting the APG target. States made several changes to their QRIS, such as opening eligibility to family child care providers, expanding from a pilot program to statewide program, and implementing new consumer education efforts.



**Head Start Teachers with Degrees in Early Childhood Education.** Head Start has shown a steady increase in the number of Head Start teachers with an Associate of Arts (AA), Bachelor of Arts (BA), or other advanced degree in early childhood education, supported by plans to improve the qualifications of staff. Based on the most recent data available from FY 2014, 95.5 percent of Head Start teachers (41,977 out of 43,946) had an AA degree or higher, missing the target of 100 percent but improving significantly since 2008. Additionally, 66 percent of Head Start teachers have a BA degree or higher, far exceeding the statutory requirement of 50 percent.

*Percentage of Head Start Teachers with AA, BA, Advanced Degree, or Other Degree  
 in a Field Related to Early Childhood Education*  
 (\* result met or exceeded target)<sup>2</sup>



<sup>2</sup> Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.



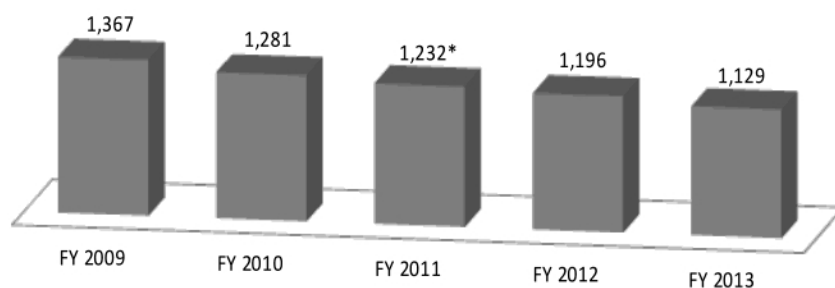
**Combustible Tobacco Consumption (Cigarette Equivalents).**

Smoking and secondhand smoke kill an estimated 480,000 people in the U.S. each year. For every smoker who dies from a smoking-attributable disease, another 30 live with a serious smoking-related disease. Smoking costs the U.S. \$133 billion in medical costs and \$156 billion in lost productivity each year. While smoking among adults in the U.S. has decreased significantly from a decade ago, the decline in adult smoking rates has slowed, concurrent with reductions in state investments in tobacco control programs. In addition, the

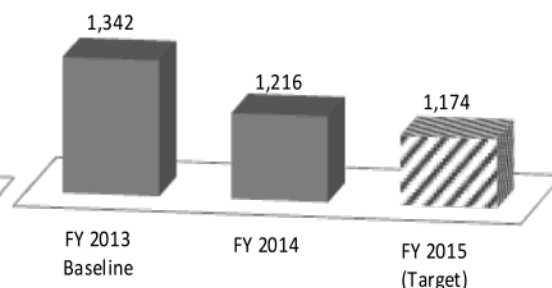
coordinated efforts of the APG to reduce combustible tobacco use ([www.performance.gov/content/reduce-combustible-tobacco-use](http://www.performance.gov/content/reduce-combustible-tobacco-use)) have resulted in reductions in adult cigarette consumption, based on FY 2013 results (reported in June 2014). In the FY 2014 – FY 2015 iteration of this APG, HHS focused on a new measure of smoking – annual per capita adult combustible tobacco consumption in the U.S. This new measure focuses on all combustibles, not just cigarettes, as a way to ascertain broader trends in tobacco use among adults. For FY 2014, the annual per capita adult combustible tobacco consumption fell to 1,216, missing the FY 2014 target of 1,212 by only four cigarette equivalents. This represents an approximate 9 percent decrease from the FY 2012 baseline of 1,342. The data represented on the left captures the results from the measure used during the previous FY 2012 – FY 2013 APG period. The data on the right represents the current measure.



*FY 2012 - 2013 APG - Reduce Cigarette Smoking*  
*Annual Per Capita Cigarette Consumption by Adults in the U.S.*  
 (\*result met or exceeded target)



*FY 2014 - 2015 APG - Reduce Combustible Tobacco Use*  
*Annual Per Capita Adult Combustible Tobacco Consumption in the U.S.*  
 (\*result met or exceeded target)<sup>2</sup>



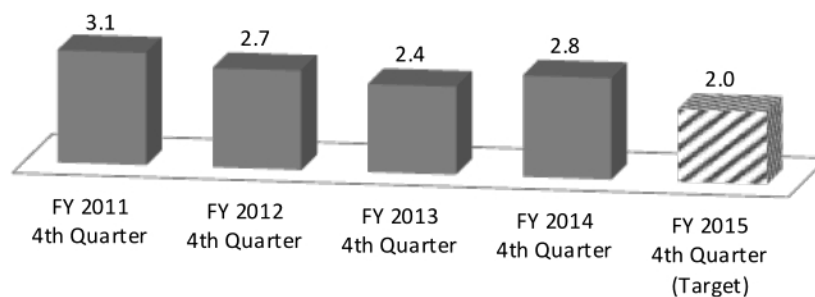
**Rate of Salmonella Enteritidis Illness.** Salmonella is the leading known cause of bacterial foodborne illness and death in the U.S. Each year in the U.S., Salmonella causes an estimated 1.2 million illnesses and between 400 and 500 deaths. Salmonella serotype enteritidis (SE), a subtype of Salmonella, is now the most common type of Salmonella in the U.S. and accounts for approximately 20 percent of all salmonella cases in humans; reducing its prevalence supports the HHS Priority Goal to reduce foodborne illness in the population ([www.performance.gov/content/reduce-foodborne-illness-population](http://www.performance.gov/content/reduce-foodborne-illness-population)).

The most significant sources of foodborne SE infections are shell eggs (FDA-regulated) and broiler chickens (U.S. Department of Agriculture-regulated). Therefore, reducing SE illness from shell eggs is the most appropriate FDA strategy for reducing illness from SE. Preventing Salmonella infections depends on actions taken by regulatory agencies, the food industry, and consumers to reduce contamination of food, as well as actions taken for detecting and responding to outbreaks.

<sup>2</sup> Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

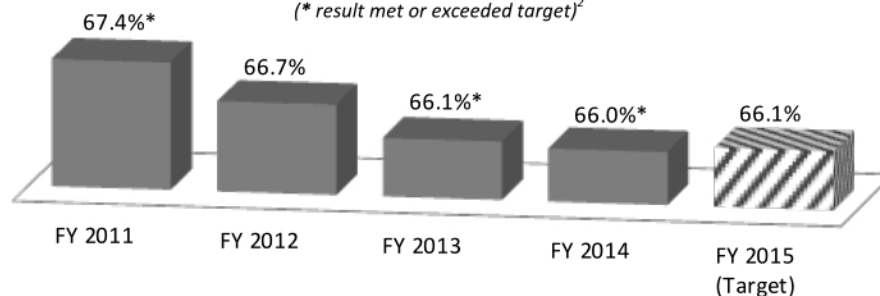
As part of the shared vision to reduce foodborne illness, FDA has developed a priority goal to reduce Salmonella contamination in shell eggs, and CDC is working with FDA to gather more data to better estimate sources of illness. CDC estimated that, for FY 2007 – FY 2009, 40 percent of domestically acquired, foodborne SE illnesses were from eating shell eggs and 28 percent of total SE illnesses (foodborne, non-foodborne, and international travel-associated) were from shell eggs. CDC completed an evaluation of a “food product” model to estimate annual change in percentage of SE illnesses from shell eggs, but determined that necessary data about contamination of shell eggs were not available. CDC concluded that this model could not be used unless new sources of egg data were obtained. Therefore, as of January 2014, CDC began collecting exposure data from persons with SE infection in FoodNet sites, a network that conducts surveillance for infections diagnosed by laboratory testing of samples from patients. CDC will conduct a preliminary evaluation of this data to assess its quality and determine its usefulness in updating CDC’s exposure model for estimating the proportion of total SE illnesses attributable to shell eggs during 2014 – 2015. While information is collected quarterly, targets are generally set annually. FDA and CDC will continue to discuss sampling strategies for collection, to assure progress on data sharing, and to identify and remove any obstacles in achieving targets.

**APG – Reduce Foodborne Illness in the Population**  
*Rate of Salmonella Enteritidis Illness in the Population*  
 (\* result met or exceeded target)<sup>2</sup>



**Adults Receiving Homeless Support Services with Positive Follow-Up.** One of SAMHSA’s goals in its Strategic Initiative on Recovery Support is to ensure that permanent housing and supportive services are available for individuals with mental and substance use disorders. A way to meet this goal is to ensure the most vulnerable individuals who experience chronic homelessness receive access to sustainable permanent housing, treatment, and recovery support through grant funds and mainstream funding sources. Target populations include veterans and individuals with serious mental illness and/or substance use disorders who experience chronic homelessness. A measure of the effectiveness of this effort is to determine overall physical and emotional health status, from the consumer’s perception of his or her recent functioning. Following the initial 13-percentage-point increase from FY 2008 to FY 2009, the percentage has consistently remained over 60 percent. FY 2014 progress indicated continued sustained performance.

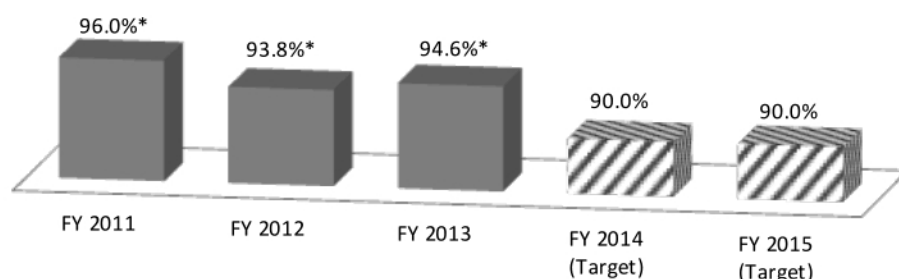
*Percentage of Adults Receiving Homeless Support Services who Report Positive Functioning at 6 Month Follow-up*  
 (\* result met or exceeded target)<sup>2</sup>



<sup>2</sup> Data results were not available at the time of publication. Results should be available in the FY 2017 Annual Performance Plan and Report published in February 2016.

**National Family Caregiver Support Program.** ACL's Administration on Aging (AoA) Family Caregiver Support Services enables family members who have a loved one with disabilities or conditions that require assistance to use an array of supportive services, including respite care, information and assistance, support groups, and training. Caregivers are frequently under substantial strain with the responsibilities of caring for their ill relatives while also caring for children or other family members while employed. Since 2008, Family Caregiver Support Services clients have rated services good to excellent consistently above the target level of 90 percent. Nearly 90 percent of respondents reported that the services helped them to be a better caregiver, and nearly three quarters report feeling less stressed due to the services.

*Percentage of National Family Caregiver Support Program clients who rate services good to excellent  
(\* result met or exceeded target)<sup>2</sup>*

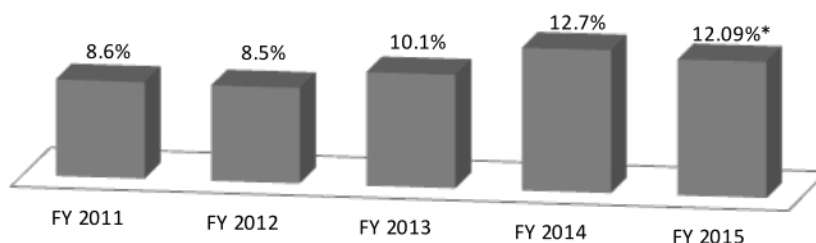


#### **Strategic Goal Four: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs**

As the largest grant-awarding agency in the federal government and the nation's largest health insurer, HHS places a high priority on ensuring the integrity of its expenditures. HHS manages hundreds of programs in basic and applied science, public health, income support, child development, and health and social services, which award over 75,000 grants annually. The Department has robust processes in place to manage the resources and information employed to support programs and activities.

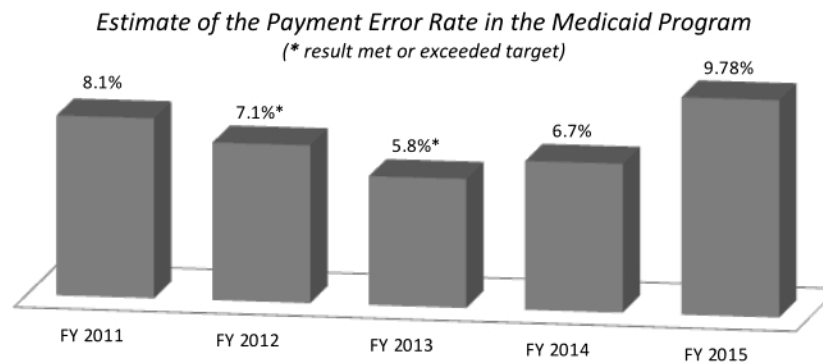
**Medicare and Medicaid Improper Payment Rates.** One of CMS's key goals is to pay Medicare claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. Paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable dollars. The Medicare fee-for-service improper payment rate in FY 2015 was 12.09%. The primary cause of improper payments is lack of documentation to support the services or supplies billed to Medicare, or Insufficient Documentation to Determine errors. The other causes of improper payments are classified as Medical Necessity errors and Administrative or Process Errors Made by Other Party, due to incorrect coding errors. CMS continues to implement corrective actions to address the agency vulnerabilities.

*Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program  
(\* result met or exceeded target)*



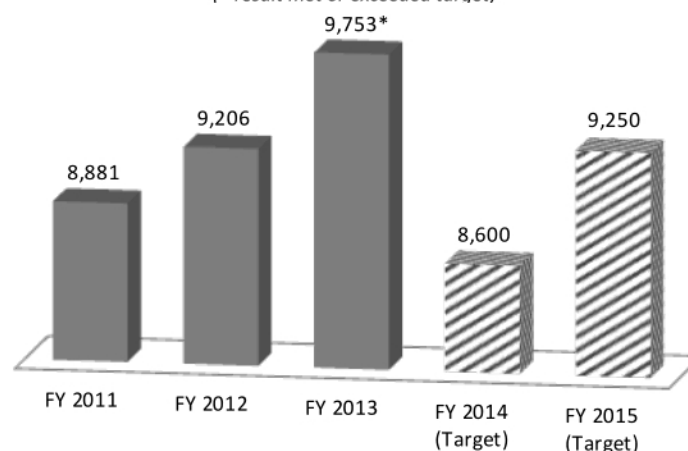
<sup>2</sup> Data results were not available at the time of publication. Results should be available in the FY 2017 Annual Performance Plan and Report published in February 2016.

Since roughly one third of the states are measured each year to calculate the Medicaid improper payment rates, these measures are calculated as a rolling rate that includes the reporting year and the previous two years. The Medicaid improper payment rate in FY 2015 was 9.78 percent. The increase was due to state difficulties bringing systems into compliance with new requirements for: (1) all referring or ordering providers to be enrolled in Medicaid, (2) states to screen providers under a risk-based screening process prior to enrollment, and (3) the inclusion of the attending provider National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen the integrity of the program, they require systems changes and, therefore, many states had not fully implemented these new requirements. CMS works closely with states to develop state-specific corrective action plans that address improper payments and describe systems updates to bring states into compliance. In an attempt to reduce the national Medicaid error rates, states are required to develop and submit state-specific corrective action plans.



**Clients Served by Home and Community-Based Services.** A key factor contributing to ACL's program success is access to Home and Community-based Services. Between FY 2008 and FY 2013, performance has improved by 17.5 percent, without benefit of adjustment for inflation. In FY 2013, the Aging Services Network served 9,753 clients per million dollars of *Older Americans Act* funding, exceeding the target of 8,700 clients per million dollars. Performance trended upward and performance targets were consistently attained. This reflects the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers, along with increased commitments and partnerships at the state and local levels, have all had positive impacts on program efficiency. Between FY 2014 and FY 2017, however, the targeted number of clients served is expected to vary as delayed effects of sequestration may occur.

*Number of Clients Served by Home and Community-Based Services, including Nutrition and Caregiver Services, per Million Dollars of Title III Older Americans Act Funding*  
(\* result met or exceeded target)<sup>2</sup>



<sup>2</sup> Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

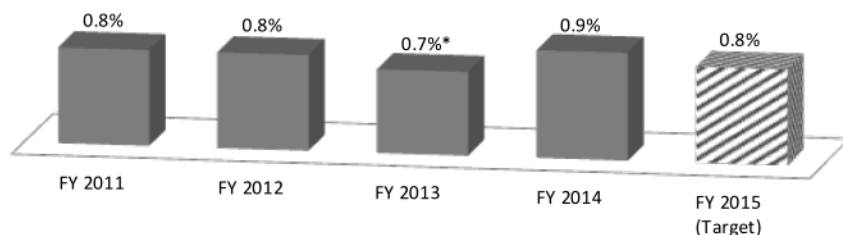
ACF's Head Start program works to ensure that the maximum number of children are served and that federal funds are used appropriately and efficiently by measuring under-enrollment across programs. Since Head Start grantees range in size from super-grantees with multiple delegate agencies serving up to 20,000 children to individual centers that serve as few as 15 children, a national under-enrollment rate better captures the under-enrollment than the proportion of grantees that meet under-enrollment targets. An un-enrolled space or vacancy in Head Start is defined as a funded space that is vacant for over 30 days.



Though each Head Start program is required to keep a wait list to fill vacancies as they occur, there are a number of reasons that it may be difficult to fill vacancies quickly. Low-income families are often mobile and eligible families on the waiting list may have moved out of the service area. In addition, as state pre-kindergarten programs grow, parents may choose to send their children to those programs. The most recent data available indicate that, during the 2013-2014 program year, Head Start grantees had, on average, not enrolled 0.9 percent (0.88 percent) of the children they were funded to serve, missing the FY 2014 target of 0.6 percent. This represents approximately 8,200 children who could have been served using the Head Start funds appropriated and awarded to grantees.

*Decrease in the Under-Enrollment Rate of Head Start Programs;  
Increased Number of Children Served Per Dollar*

(\* result met or exceeded target)<sup>2</sup>



## Cross-Agency Priority Goals

Cross-Agency Priority goals address the longstanding challenge of tackling horizontal problems across vertical organizational silos. In the 2015 President's Budget, 15 Cross-Agency Priority Goals were announced – seven mission-oriented and eight management-focused goals with a four year time horizon. Established by the *GPR Modernization Act of 2010*, these Cross-Agency Priority Goals are a tool used by federal leadership to accelerate progress on a limited number of Presidential priority areas where implementation requires active collaboration between multiple agencies. HHS contributes to Cross-Agency Priority Goals with other federal agencies in the mission-oriented goals of Science, Technology, Engineering and Mathematics (STEM) Education; and Service Members and Veterans Mental Health. We are also maximizing federal spending through participation in the management-focused goals of Shared Services; Benchmark and Improve Mission-Support Operations; and Customer Service. For more information on HHS's contributions to Cross-Agency Priority Goals and progress, refer to [www.performance.gov](http://www.performance.gov).

<sup>2</sup> Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

## SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROLS

### Systems

#### *Financial Systems Environment*

HHS's CFO Community strives to provide effective stewardship of taxpayer funds through transparency and accountability in support of the Department's mission and programs. The HHS financial systems environment forms the financial and accounting foundation for managing the \$1.5 trillion in budgetary resources entrusted to the Department in FY 2015. These resources represent about a quarter of all federal outlays and encompass more grant dollars than all other federal agencies combined.

The robust financial systems environment supports a diverse portfolio of programs and business operations. Its purpose is to: provide complete and accurate financial information for decision-making; improve data integrity; strengthen internal controls; and mitigate risk.

The HHS financial systems environment consists of a core financial system (with three instances) and two Department-wide reporting systems used for financial and managerial reporting that – taken together – satisfy the Department's financial accounting and reporting needs.

#### *Core Financial System*

The core financial system operates on a commercial off-the-shelf (COTS) platform to support data standardization and facilitate Department-wide reporting. Each of the instances operates the same COTS solution.

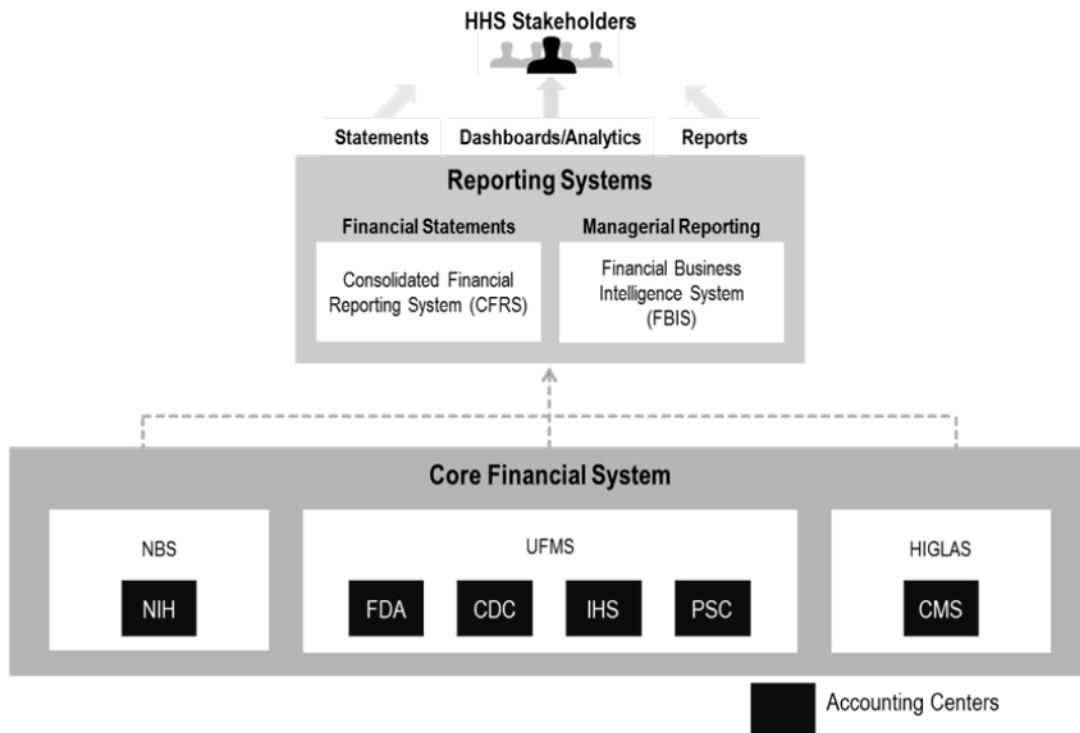
- The NIH Business System (NBS) serves NIH's 27 research institutes and accounts for nearly \$27.5 billion in annual grants payments.
- The Unified Financial Management System (UFMS) serves 10 OpDivs (including the OS) and 18 StaffDivs across the Department. The following accounting centers utilize UFMS: CDC, FDA, IHS, and PSC. PSC provides shared service accounting support for the rest of the Department.
- The Healthcare Integrated General Ledger Accounting System (HIGLAS) supports CMS. HIGLAS serves 15 Medicare Administrative Contractor organizations, Administrative Program Accounting, and the Center for Consumer Information and Insurance Oversight. It processes an average of five million transactions daily.

#### *Reporting Systems*

Reporting components within the HHS financial systems environment consist of two Department-wide applications: Consolidated Financial Reporting System (CFRS) and Financial Business Intelligence System (FBIS). These reporting systems facilitate data reconciliation, financial and managerial reporting, and data analysis.

- CFRS systematically consolidates information from all three instances of the core financial system. It generates Departmental quarterly and year-end consolidated financial statements on a consistent and timely basis while supporting HHS in meeting regulatory reporting requirements.
- FBIS is a financial business intelligence application for managerial reporting. It consolidates information from the core financial system to support strategic and operational reporting requirements. FBIS utilizes a variety of business intelligence techniques to present data for decision-making, including metrics and key performance indicators, dashboards with graphical displays, interactive reports, and ad-hoc reporting.

The illustration below depicts the current financial systems environment.



The HHS financial systems environment is required to comply with all relevant federal laws, regulations, and authoritative guidance. In addition, HHS must conform to federal financial systems requirements including:

- *Federal Managers' Financial Integrity Act of 1982*
- *Chief Financial Officers Act of 1990*
- *Government Management Reform Act of 1994*
- *Federal Financial Management Improvement Act of 1996*
- *Clinger-Cohen Act of 1996*
- *Federal Information Security Management Act of 2002*
- *Digital Accountability and Transparency Act (DATA Act) of 2014*
- *Federal Information Technology Acquisition Reform Act of 2014*
- Office of Management and Budget (OMB) directives related to these laws

#### **Financial Systems Environment Improvement Strategy**

HHS continues to implement a Department-wide strategy to advance its financial systems environment through the Financial Systems Improvement Program (FSIP) and Financial Business Intelligence Program (FBIP). The goal of the strategy is to improve the effectiveness and efficiency of the Department's financial management capabilities and to mature the overall financial systems environment. This is a multi-year initiative, and the Department is making significant progress in each of the following key strategic areas.

### Governance

- *Strategy:* In November 2013, the Department established the Financial Management Governance Board (FGB) to address enterprise-wide issues, including those related to financial policies and procedures, financial data, and technology. The FGB's goals include establishing HHS financial management governance; providing people, processes, and technology to support governance; engaging stakeholders through effective communication and management strategies; and supporting project alignment with federal mandates and priorities.
- *Progress:* Since its inception, the FGB has met monthly and facilitated executive-level oversight of financial management-related areas. It promotes collaboration among stakeholders from the different disciplines within the financial management community by engaging senior leadership from HHS OpDivs and StaffDivs and across functions such as finance, budget, grants, and information technology (IT). Further, it has become a key forum to address pervasive audit findings related to governance through regular decision-making meetings and clear documentation to support actions taken.

### Program Management

- *Strategy:* To support FSIP, HHS has established a Department-wide program management framework to facilitate effective implementation of FSIP projects and to enhance collaboration across project teams. This includes the Financial Systems Consortium: a body of contractors, federal project managers, and federal contracting officers representing NBS, UFMS, and HIGLAS, that foster communication and implement best practices.
- *Progress:* Department-wide program management and the Consortium have been critical in coordinating the overall upgrade of the HHS core financial system through communication with HHS leadership and key external stakeholders. Through this framework, project teams have been able to share industry best practices, lessons learned, and risks identified during the upgrade while minimizing overall costs. This has included sharing solutions across system upgrade teams to streamline implementation, as well as coordinating vendor support to resolve software issues. Effective program management has also reduced duplication of effort and costs by identifying potential sharing opportunities and improvements.

### Accounting Treatment Manual and Data Standardization

- *Strategy:* HHS is incrementally developing and implementing a standardized Department-wide Accounting Treatment Manual (ATM) that will improve fiscal transparency and accountability, while enhancing the accuracy of financial reporting.
- *Progress:* HHS completed its initial development of a Department-wide ATM in April 2014, and recommendations are being implemented concurrently with the system upgrade. The FGB has chartered the Data Standardization Working Group (DSWG), which meets on a quarterly basis, leads ATM changes, and coordinates with the HHS DATA Act Program Management Office (PMO) on DATA Act implementation.

### Financial System Upgrade

- *Strategy:* A critical component of the multi-year FSIP initiative is upgrading the core financial system to the most current version of the COTS software to maintain a secure and reliable financial systems environment. In 2014, HHS began the upgrade in phases, while continuing to support current operations.



In addition, a post-upgrade roadmap was developed for implementing future projects and enhancements to further mature the HHS financial systems environment.

- *Progress:* The NBS and HIGLAS upgrades were completed and put into production during FY 2015. The UFMS upgrade is on-track for completion in FY 2016, as planned. Project teams leveraged the upgrade to identify opportunities for reducing or consolidating many customizations.

### Sharing

- *Strategy:* As a key FSIP component, HHS is actively pursuing multiple initiatives to generate efficiencies and improve effectiveness through implementing shared solutions. The Department has also established a framework for continuously identifying sharing opportunities in its financial systems environment.
- *Progress:* Examples of sharing opportunities pursued to date include transitioning the financial system to a cloud shared service provider; the use of shared acquisition contracts and consolidation of system operations and maintenance contracts; the development of a Department-wide ATM; and sharing solutions across the HHS financial community. The FGB will assess future opportunities to ensure alignment with financial management and system policies, business processes and operations, and the overall financial system vision and architecture.

### Business Intelligence

- *Strategy:* Leveraging the FBIS platform, HHS is expanding the use of business intelligence with the goals of further enhancing financial management information and reporting, as well as facilitating effective decision-making.
- *Progress:* Since first deployed in FY 2012, FBIS has been providing operational and business intelligence to users across the HHS finance, budget, grants, and acquisition communities. FBIS provides accurate, consistent, near real-time data from UFMS, and summary data from HIGLAS and NBS, supporting over 1,500 users across the Department, with plans to have over 2,000 users by the end of 2015.

### Systems Policy and Compliance

- *Strategy:* HHS has placed a high-priority on maturing and enhancing its financial systems control environment, strengthening policy, proactively monitoring emerging issues, and ensuring progress towards remediating the Department's IT Material Weakness. HHS is implementing a policy management program to standardize development, implementation, and monitoring of financial systems policies.
- *Progress:* HHS addresses the Department's IT material weakness by analyzing audit findings, identifying root causes, and implementing solutions collaboratively. The FGB chartered an IT Material Weakness Working Group (MWWG), with members from OpDiv Chief Information Officer (CIO), Chief Financial Officer (CFO), and Chief Information Security Officer (CISO) communities. The IT MWWG developed a roadmap to address pervasive issues, recommend comprehensive remediation approaches, and monitor implementation progress. HHS has also initiated projects to develop role-based security controls and identify areas to enhance and automate additional internal controls.

## Legal Compliance

### ***Anti-Deficiency Act***

The *Anti-Deficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, or before funds are available, or from accepting voluntary services. As required by the ADA, HHS notifies all appropriate authorities of any ADA violations. ADA reports can be found at [www.gao.gov/legal/anti-deficiency-act/about](http://www.gao.gov/legal/anti-deficiency-act/about).

HHS management is taking necessary steps to prevent future violations. With respect to three possible issues, we are working through investigations and further assessment where necessary. We remain fully committed to resolving these matters appropriately and complying with all aspects of the law.

### ***Digital Accountability and Transparency Act of 2014***

The *DATA Act* expands the *Federal Funding Accountability and Transparency Act of 2006* to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. It directs the federal government to use government-wide data standards for developing and publishing reports, and to make more information, including award-related data, available on [www.USAspending.gov](http://www.USAspending.gov). Among other goals, the *DATA Act* aims to improve the quality of the information on [www.USAspending.gov](http://www.USAspending.gov), as verified through regular audits of the posted data, and to streamline and simplify reporting requirements through clear data standards. Additionally, the *DATA Act* accelerated the referral of delinquent debt owed to the federal government to the Treasury's Offset Program (TOP) after 120 days of delinquency.

HHS is actively implementing requirements of the *DATA Act*. One of the Department's initial moves was to establish the *DATA Act* PMO to facilitate a collaborative Department-wide approach to implementation. We have updated applicable Department financial management policy, reduced our delinquent debt referral window from 180 days to 120 days, and we are auditing the information on [www.USAspending.gov](http://www.USAspending.gov). HHS also revamped our ATM to facilitate data standards throughout the Department.

### ***Improper Payments Information Act of 2002, Improper Payments Elimination and Recovery Act of 2010, and the Improper Payments Elimination and Recovery Improvement Act of 2012***

An improper payment occurs when a payment should not have been made, federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, the recipient uses the funds in an improper manner, or documentation is not available to verify the appropriateness of the payment. The *Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA), and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA), requires federal agencies to review their programs and activities, identify programs that may be susceptible to significant improper payments, perform testing of programs considered high risk, and develop and implement corrective action plans for high risk programs. HHS is striving to better detect and prevent improper payments through close review of our programs and activities using sound risk models, statistical estimates, and internal controls. A detailed report of HHS's improper payment activities and performance is presented in the "Other Information" section of this AFR, under "Improper Payments Information Act Report."

### ***Patient Protection and Affordable Care Act***

The *Affordable Care Act* implements comprehensive health care reform to make quality health care more affordable and accessible. The *Affordable Care Act* includes provisions for a patient's bill of rights, a Health Insurance Marketplace, tax credits for low-income Americans, incentives for high-quality care from physicians, and expansion of the Medicaid program, helping to provide access to affordable health insurance options for all Americans.

The *Affordable Care Act* also aims to reduce health care fraud, waste and abuse by toughening the sentences for perpetrators of fraud, employing enhanced screening procedures, improving the monitoring of providers, and using predictive modeling technology to target suspect behaviors. These efforts have enabled the government to recover billions of dollars related to improper payments over the last five years. For detailed information on improper payment recovery efforts, see the "Program-Specific Reporting Information" section of the "Improper Payments Information Act Report."

A key aspect of the *Affordable Care Act* allows eligible Americans to receive a premium tax credit when purchasing their health insurance coverage through the Health Insurance Marketplace. The amount of the credit can be paid in advance directly to the consumer's health insurer. Consumers then claim the premium tax credit on their federal tax returns, reconciling the credit allowed with any advance payments made throughout the tax year. HHS coordinates closely with the Internal Revenue Service (IRS) on this process.

HHS has implemented many provisions of the *Affordable Care Act*. For more information about implementation of the many *Affordable Care Act* provisions, visit the "Key Features" page at [www.hhs.gov/healthcare/facts/timeline/timeline-text.html](http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html).

#### ***Federal Information Technology Acquisition Reform Act***

The *Federal Information Technology Acquisition Reform Act* (FITARA) passed Congress in December 2014 and OMB followed with final implementation guidance in June 2015. FITARA established an enterprise-wide approach to federal IT investments and provides the CIO of *CFO Act* agencies with greater authority over IT investments, including authoritative oversight of IT budgets and budget execution, as well as IT-related personnel practices and decisions. FITARA also promotes cross-functional partnerships between CIOs and senior agency officials to facilitate the enterprise-wide approach to IT management. HHS's senior officials, including the CIO, CFO, Chief Human Capital Officer, and Chief Acquisition Officer, have collaborated on a FITARA Implementation Plan, which the Department is coordinating with OMB for approval.

#### ***Federal Managers' Financial Integrity Act of 1982 and Federal Financial Management Improvement Act of 1996***

The *Federal Managers' Financial Integrity Act of 1982* (FMFIA) requires federal agencies to annually evaluate and assert on the effectiveness and efficiency of their internal control and financial management systems. Agency heads must annually provide a statement on whether there is reasonable assurance that the agency's internal controls are achieving their intended objectives and the agency's financial management systems conform to government-wide requirements. Section 2 of FMFIA outlines compliance with internal control requirements, while Section 4 dictates conformance with systems requirements. Additionally, agencies must report on any identified material weaknesses and provide a plan and schedule for correcting the weaknesses.

In September 2014, the U.S. Government Accountability Office (GAO) released an updated edition of its *Standards of Internal Control in the Federal Government*, effective FY 2016. The document includes several new principles and priorities, including a focus on a framework for Enterprise Risk Management (ERM). OMB is also expected to release in FY 2016 an updated version of Circular A-123, titled *Management's Responsibility for Risk Management and Internal Control*. The new Circular will complement GAO's *Standards*, and will implement requirements of the FMFIA with the intent to improve accountability in federal programs and increase federal agencies' consideration of ERM. The Department and its OpDiv and StaffDiv stakeholders will coordinate and collaborate to implement the new requirements.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems to mandated requirements. FFMIA expanded upon FMFIA by requiring that agencies implement and maintain financial management systems that substantially

comply with federal financial management systems requirements, applicable federal accounting standards, and the U.S. Standard General Ledger at the transaction level. Guidance for determining compliance with FFMIA is provided in OMB Circular A-123, Appendix D, *Compliance with the FFMIA of 1996*.

HHS is fully focused on the requirements of FMFIA and FFMIA through its internal control program and a Department-wide approach to risk management. Based on thorough ongoing internal assessments and FY 2015 audit findings, HHS provides reasonable assurance that controls are operating effectively. For further information, see the "Management Assurances" section. We are actively engaged with our OpDivs to correct the identified weakness, supported by a renewed emphasis on a stringent corrective action process focused on addressing the true root cause of deficiencies along with active management oversight. More information on Department's internal control efforts and the HHS Statement of Assurance follows.

Nearly half of U.S. adults do not have the resources and plans in place in the event of an emergency. Emergency kits should include a three-day supply of food and water, flashlights, chargers, and a first aid kit.



## Internal Control

FMFIA requires agency heads to annually evaluate and report on the internal control and financial systems that protect the integrity of federal programs. This evaluation aims to provide reasonable assurance that internal controls are achieving the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives. Since FY 2006, HHS has performed rigorous evaluations of its internal controls in compliance with OMB Circular A-123, *Management's Responsibility for Internal Control*.

HHS management is directly responsible for establishing and maintaining effective internal controls in their respective areas of responsibility. As part of this responsibility, management regularly evaluates internal control and HHS executive leadership provides annual assurance statements reporting on the effectiveness of controls at meeting objectives. The HHS Risk Management and Financial Oversight Board (RMFOB) evaluates the OpDivs' management assurances and recommends a Department assurance for the Secretary's consideration. The Secretary's annual Statement of Assurance follows.

HHS aims to strengthen its internal control assessment and reporting process to more effectively identify key risks, develop effective risk responses, and implement timely corrective actions. The HHS FY 2015 OMB Circular A-123 assessment and the financial statement audit reported one material weakness in Information System Controls and Security, which also constitutes a non-conformance under Section 4 of FMFIA. Additionally, HHS recognizes one material noncompliance with IPIA regarding Error Rate Measurement. These material findings were also reported in FY 2014.

Maintaining integrity and accountability in all programs and operations is critical to HHS's mission and demonstrates responsible stewardship over assets and resources. It also promotes responsible leadership, ensures the effective delivery of high quality services to the American people, and maximizes desired program outcomes.

 **DID YOU KNOW**

Flu season usually peaks in January or February, but it can occur as late as May. Early immunization is most effective, but it is not too late to get the vaccine in December, January, or February. Everyone over 6 months of age is recommended to get the vaccine every year.

Visit [flu.gov](http://flu.gov) to use the flu vaccine finder.



Secretary Burwell receives her flu shot.

## MANAGEMENT ASSURANCES

### Statement of Assurance



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

The Department of Health and Human Services' (HHS or the Department) management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of the *Federal Managers' Financial Integrity Act* (FMFIA) and Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*. These objectives are to ensure (1) effective and efficient operations; (2) compliance with applicable laws and regulations; and (3) reliable financial reporting. The safeguarding of assets is a subset of these objectives.

As required by OMB Circular A-123, HHS has evaluated its internal control and financial management systems to determine if these objectives are being met. The Department provides reasonable assurance that internal controls were operating effectively as of September 30, 2015, with the exception of one material weakness related to Information System Controls and Security (which also constitutes a system non-conformance) and one material noncompliance with the *Improper Payments Information Act* (IPIA) related to Error Rate Measurement.

Remediation for the material weakness is underway, as described in the "Corrective Action Plans for Material Deficiencies" section. Remediation for the material noncompliance relies on a modification to legislation to require states to participate in an improper payment rate measurement.

#### Internal Control over Financial Reporting (ICOFR)

HHS conducted its assessment of the effectiveness of ICOFR, which includes safeguarding assets and compliance with applicable laws and regulations, in accordance with the requirements of OMB Circular A-123, Appendix A. Other than the one material weakness mentioned above, the Department provides reasonable assurance that internal controls over financial reporting were operating effectively as of June 30, 2015.

#### Internal Control over Operations and Compliance

HHS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with OMB Circular A-123. Other than the one material weakness and the one material noncompliance mentioned above, the Department provides reasonable assurance that internal control over operations and compliance with applicable laws and regulations was operating effectively as of September 30, 2015.

**Federal Financial Management Improvement Act of 1996 (FFMIA)**

FFMIA requires agencies to implement and maintain financial management systems that substantially comply with federal financial management system requirements, federal accounting standards, and the United States Standard General Ledger at the transaction level. HHS conducted its evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. As mentioned above, HHS identified one material weakness, which also constitutes a system non-conformance under FMFIA, Section 4, and as a result determined that its financial management systems neither fully comply with the FFMIA, nor fully conform to the objectives of FMFIA, Section 4. The Department is nearing completion of a phased, enterprise-wide financial system upgrade that will address many factors contributing to the material weakness, with stabilization expected in Fiscal Year (FY) 2016.

HHS will continue to ensure accountability and transparency over the management of taxpayer dollars, and strive for the continuing progress and enhancement of its internal control and financial management programs.

/Sylvia M. Burwell/

Sylvia M. Burwell  
Secretary  
November 13, 2015

## Summary of Material Weaknesses

Control Areas	FMFIA Section 2			FMFIA Section 4
	Financial Reporting (As of 6/30/2015)	Operations (As of 9/30/2015)	Compliance (As of 9/30/2015)	System Non-Conformance (As of 9/30/2015)
1. Information System Controls and Security	1	1	0	1
2. Error Rate Measurement	0	0	1	0

### 1. Information System Controls and Security

HHS acknowledges a material weakness related to Information System Controls and Security. This material weakness includes general and application controls specifically related to segregation of duties, access controls, and configuration management, as well as other information system security weaknesses that were identified through the annual *Federal Information Systems Control Audit Manual*, *Federal Information Security Management Act* (FISMA), and other internal management reviews. While no single financial management system had a material weakness, the pervasive nature of the deficiencies throughout the Department leads management to conclude that these aggregate deficiencies warrant classification as a material weakness under Section 2 of FMFIA and a non-conformance under Section 4 of FMFIA. While the Department has made progress in the remediation of this material weakness, our financial management systems are not yet in substantial compliance with FMFIA and its associated regulatory guidelines.

### 2. Error Rate Measurement

HHS did not identify any material weaknesses in our internal control over compliance with applicable laws and regulations; however, HHS reports a statutory limitation relating to the Temporary Assistance for Needy Families (TANF) program that results in one material noncompliance with IPIA. The TANF program is not reporting an error rate for FY 2015, as required by IPIA, because statutory limitations currently prohibit HHS from requiring states to provide information needed for determining a TANF improper payment measurement.



## Corrective Action Plans for Material Deficiencies

### 1. Information System Controls and Security

HHS has placed a high priority on remediating the Information System Controls and Security material weakness and maturing its financial systems control environment through strengthening policy, proactively monitoring emerging issues, and ensuring progress toward correcting deficiencies contributing to the material weakness. A Department-wide IT Material Weakness Working Group (MWWG) was established in FY 2015 with members from the Chief Financial Officer, Chief Information Officer, and Chief Information Security Officer communities to collaboratively identify challenges, conduct root cause analyses, and jointly implement comprehensive solutions. In FY 2015, the IT MWWG developed a roadmap for improving the financial systems safeguards related to segregation of duties, access controls, configuration management, and FISMA weaknesses that contribute to the Information System Controls and Security material weakness.

Additional efforts are required beyond FY 2015 to address the range of challenges stemming from HHS's Information System Controls and Security material weakness and system non-conformance. In FY 2016, HHS will continue its collaborative efforts to identify high risk areas within the HHS financial systems environment, develop remediation plans, and monitor corrective action implementation to meet the Department's objectives. HHS will continue to report remediation progress to the Risk Management and Financial Oversight Board and maintain accountability and commitment to strengthen the HHS financial systems environment.

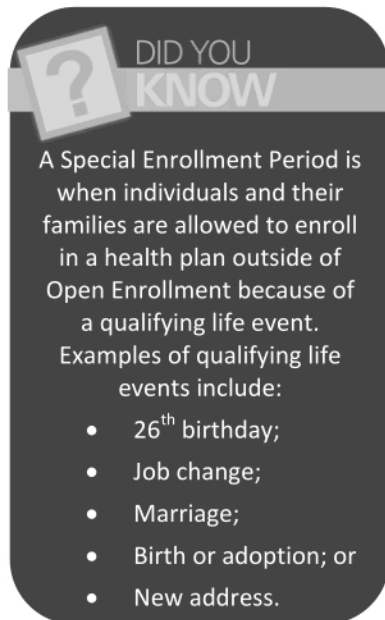
### 2. Error Rate Measurement

Current statutory limitations restrict corrective actions HHS can take to develop an error rate for TANF. HHS plans to encourage Congress to consider statutory modifications that would allow for reliable error rate measurement when legislation is considered to reauthorize TANF.

## LOOKING AHEAD TO 2016

HHS is the U.S. government's principal agency for protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. Guided by the HHS Strategic Plan, 2016 will be crucial in supporting continuing Health Insurance Marketplace operations as well as many other efforts in a number of exciting and challenging areas.

### Strengthen Health Care



**DID YOU KNOW**

A Special Enrollment Period is when individuals and their families are allowed to enroll in a health plan outside of Open Enrollment because of a qualifying life event. Examples of qualifying life events include:

- 26<sup>th</sup> birthday;
- Job change;
- Marriage;
- Birth or adoption; or
- New address.

HHS is responsible for implementing many of the provisions included in the *Affordable Care Act*, which makes health insurance coverage more secure and reliable for Americans, makes coverage more affordable and accessible for families and small business owners, and helps bring down health care costs. The *Affordable Care Act* also expands consumer choice, supports informed decision making, and increases health insurance coverage for low-income populations, partly through the expansion of Medicaid eligibility and the advent of the Health Insurance Marketplace, which launched on October 1, 2013. Medicaid enrollment has grown from 57.8 million enrollees in September 2013 to 70.0 million enrollees in January 2015, which represents a 21 percent growth in enrollment.

As of June 30, 2015, about 9.9 million Americans had effectuated Health Insurance Marketplace coverage through the Health Insurance Marketplaces established by the *Affordable Care Act*. The Department is also working to strengthen the ties between Medicare payments and value as opposed to volume, a shift made possible by the *Affordable Care Act* and the *Medicare Access and CHIP Reauthorization Act (MACRA)*.

In an effort to improve access to health care, the Department continues to make significant investments in new access points and expanded services, including funding for substance abuse treatment and care, which is critical to combatting the opioid epidemic affecting our country, especially in rural communities.

### Advance Scientific Knowledge and Innovation

HHS is working to advance scientific knowledge and innovation to prevent, diagnose, and treat diseases and disorders as well as address emerging health threats, and sustain a vital and cutting edge workforce and scientific infrastructure. Future HHS plans include accelerating the development of opportunities for the prevention and treatment of substance use and abuse, researching Alzheimer's disease and related dementias, as well as human immunodeficiency virus (HIV) and reversing the national epidemic of obesity and diabetes. Research will also address health disparities, multiple chronic conditions, and cardiovascular disease, all critical health priorities facing America. In order to build on past successes, the Department will encourage initiatives focused on the President's priority areas of Precision Medicine as well as the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. The Department will also encourage advancements associated with the Cures Acceleration Network, the National Library of Medicine, and expanding the number of competing research project grants.

## Advance the Health, Safety, and Well-Being of the American People

HHS's focus will continue aligning with the Surgeon General's National Prevention Strategy, which seeks to create environments that promote healthy behaviors such as preventing and reducing tobacco use, and implementing a 21st century food safety system to reduce foodborne illness in the population. HHS will also help Americans achieve and maintain healthy weight through school-based, workplace-based, and community-based strategies.



HHS plays a crucial role in global health security. Through the Biomedical Advanced Research and Development Authority (BARDA), the Department provides an integrated, systematic approach to the advanced development and purchase of necessary vaccines, drugs, therapies, and diagnostic tools. BARDA, along with HHS and industry partners, is developing, manufacturing, and storing medical countermeasures for chemical, radiological, biological, and nuclear threats; pandemic influenza; and emerging infectious threats, and is also working to provide new options to treat antibiotic-resistant infections. The Department will also continue its effort to promote global well-being and health diplomacy, as well as create a nimble system better able to respond to unanticipated demands.

HHS plans to continue investing in efforts to prevent and manage chronic diseases and conditions, enhancing clinical efforts including childhood and adult immunizations, threat detection and response, and supporting behavioral and primary health integration. These efforts will support overall public health as well as protect Americans' health and safety during emergencies, and foster resilience in response to emergencies. Health at all ages is a priority for the Department. Continued partnering between HHS and state, local, tribal, urban Indian, and other service providers will sustain an essential safety net of services that protect children and youth, promote their emotional health and resilience in the face of adversity, and ensure their healthy development from birth through transition to adulthood. Health and early intervention services ensure children get off to a good start from infancy. To support this, HHS will maintain efforts to improve the quality of early childhood education for all children, and other efforts that will put children and youth on the path to successful futures, such as improving access to care, treatment, and services for children and youth exposed to traumatic events. Furthermore, by implementing evidence-based strategies in home visiting, foster care, and teen pregnancy prevention, HHS will ensure that this population is given the chance to succeed in adulthood and can contribute to America's success. Community living for older adults and people with disabilities will continue to be a focus area as the U.S. population over the age of 65 is projected to increase by 29 percent between 2012 and 2020.

**DID YOU KNOW**

Measles is still common in many parts of the world. Unvaccinated travelers continue to get measles in other countries and bring the disease into the U.S.

## Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs



As we near the end of this Administration, HHS leadership is committed to leaving the Department in a strong position to continue its vital work. To do this, HHS will stay committed to developing effective systems, workforce, and infrastructure that can address complicated and emerging challenges. These efforts will allow HHS to continue toward its goal of improved health and well-being among Americans. Specifically, HHS will continue its evaluation efforts, including program integrity reviews that ensure compliance with federal program integrity regulations and identify areas to improve efficiency

and effectiveness. Additionally, HHS is entrusted with a wealth of sensitive data, including personally identifiable information, financial and patient data, and biodefense research; ensuring its security is a high priority. As cybersecurity threats are constantly evolving and becoming more sophisticated, the Department will need to continually hone the skills necessary to monitor threats and quickly respond to a changing environment.

While continuing the spirit of collaboration from stakeholders throughout the Department, HHS will pursue seven APGs for FY 2016 – FY 2017. These efforts support significant improvements in near-term outcomes and advanced progress toward longer-term, outcome-focused strategic objectives. These APGs include efforts around the following areas:

- Early Childhood Education
- Combustible Tobacco Use
- Foodborne Illness
- Health Care Payment Reform
- Combating Antibiotic-Resistant Bacteria
- Opioid Abuse
- Serious Mental Illness

More information on the FY 2016 – 2017 APGs is available on [www.performance.gov](http://www.performance.gov).



## ANALYSIS OF FINANCIAL STATEMENTS AND STEWARDSHIP INFORMATION

The financial statements, which include the Consolidated Balance Sheets, Consolidated Statement of Net Cost, Consolidated Statement of Changes in Net Position, Combined Statement of Budgetary Resources, Statement of Social Insurance, and the Statement of Changes in Social Insurance Amounts, as well as the Notes discussed in this section, are prepared in conformity with U.S. generally accepted accounting principles (GAAP) established by the Federal Accounting Standards Advisory Board (FASAB). These financial statements and Notes are audited by the independent accounting firm of Ernst & Young LLP, under the direction of the Office of Inspector General. The *CFO Act* requires the preparation and audit of these statements, which are part of our efforts for continuous improvement of financial management.

Accurate, timely, and reliable financial information is necessary for making sound decisions, assessing performance, and allocating resources. The "Financial Section" of this report presents our audited financial statements and Notes. The analysis within this section is a summary of those audited statements and highlights certain significant balances and variances; supplemented by graphic presentations and explanations which help clarify their relevance to HHS.

Through OS and its 11 OpDivs, HHS administers over 300 programs for the benefit of the American people. CMS is the largest OpDiv, which oversees a significant share of the Department's financial activity. Fluctuations in the financial statements for FY 2015 over FY 2014 are primarily the result of program growth and changes at CMS. Year-over-year summary changes for each HHS financial statement are discussed in the following sections. Greater detail can be found in the "Notes to the Principal Financial Statements" in the "Financial Section" of this report.

### Balance Sheets

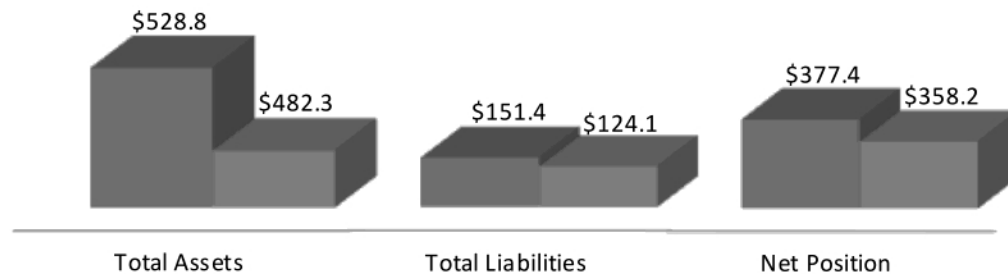
The table below summarizes current and prior year information concerning components of our financial condition as of September 30 each year. The components of the Consolidated Balance Sheets are the assets under HHS authority, the responsibilities owed by the Department, and the difference between them, or net position.

<b>Financial Condition Summary</b>			Change (2014-15)	
(in Billions)	2015	2014	\$	%
Fund Balance with Treasury	\$219.5	\$177.0	\$42.5	24%
Investments, Net	269.7	278.9	(9.2)	(3)%
Accounts Receivable	22.9	11.1	11.8	106%
Other Assets	16.7	15.3	1.4	9%
<b>Total Assets</b>	<b>\$528.8</b>	<b>\$482.3</b>	<b>\$46.5</b>	<b>10%</b>
Accounts Payable	\$0.9	\$1.0	(\$0.1)	(10)%
Entitlement Benefits Due and Payable	108.1	91.0	17.1	19%
Accrued Liabilities	14.3	3.3	11.0	333%
Federal Employee and Veterans' Benefits	12.1	12.0	0.1	1%
Other Liabilities	16.0	16.8	(0.8)	(5)%
<b>Total Liabilities</b>	<b>\$151.4</b>	<b>\$124.1</b>	<b>\$27.3</b>	<b>22%</b>
<b>Net Position</b>	<b>\$377.4</b>	<b>\$358.2</b>	<b>\$19.2</b>	<b>5%</b>
<b>Total Liabilities &amp; Net Position</b>	<b>\$528.8</b>	<b>\$482.3</b>	<b>\$46.5</b>	<b>10%</b>

### Comparative Balances

(in Billions)

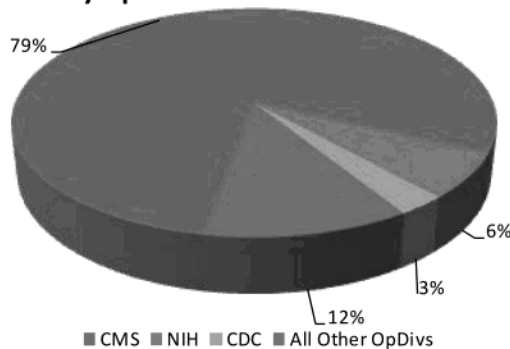
■ 2015 ■ 2014



#### Assets

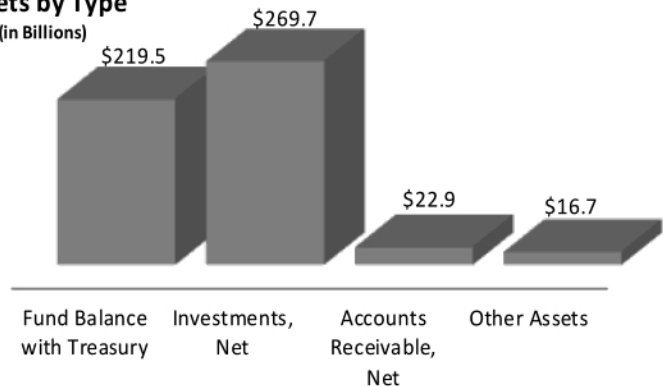
Assets represent the value of what we own and manage. Our total assets were \$528.8 billion on September 30, 2015. This amount represents an increase of \$46.5 billion or approximately 10 percent greater than last year's assets. We have experienced a slight change in the overall composition of our assets in FY 2015 compared to FY 2014. The Fund Balance with Treasury (FBwT) and Net Investments together currently comprise 93 percent of our total assets, versus 95 percent in FY 2014.

#### Assets by OpDiv



#### Assets by Type

(in Billions)



The majority of the increase in FBwT is attributable to a \$36.2 billion increase in CMS's FBwT related primarily to Supplementary Medical Insurance (SMI), CHIP, and Medicaid increases of \$25.0, \$5.6, and \$5.1 billion; respectively. Other notable changes in the FBwT include a \$1.8 billion direct appropriation increase for CDC to support the Emergency Ebola Response and Preparedness.

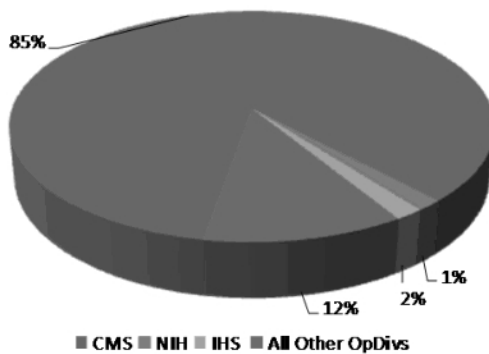
Out of the \$11.8 billion Accounts Receivable increase, \$11.0 billion is attributable to CMS. This is largely attributable to the \$10.0 billion Accounts Receivable increase related to the *Affordable Care Act*. FY 2015 Other Assets, totaling \$16.7 billion, consist of: Inventory and Related Property (\$9.5 billion); General Property, Plant and Equipment (PP&E) (\$5.9 billion); and Other Assets such as Travel Advances and Direct Loans (totaling \$1.3 billion).

HHS reports PP&E exclusive of Stewardship Land, which comprises land held by IHS for providing health services to American Indians and Alaska Natives. HHS invests in other stewardship assets such as, Investments in Human Capital and in Research and Development. A discussion of stewardship assets is presented in Note 20 and in the "Required Supplementary Stewardship Information" within the "Financial Section."

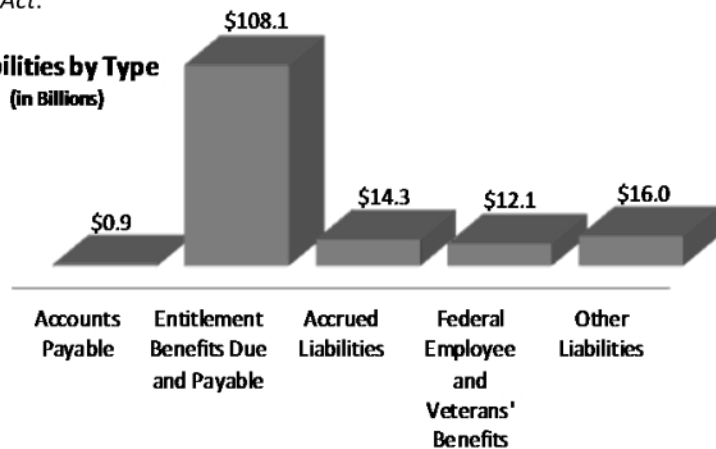
### Liabilities

Our liabilities, or amounts that we owe from past transactions or events, were \$151.4 billion on September 30, 2015. This represents an increase of \$27.3 billion, or 22 percent more than the FY 2014 liabilities, primarily due to the Entitlement Benefits Due and Payable at CMS (\$17.1 billion) for SMI, Medicaid, and Hospital Insurance (HI) claims Incurred But Not Reported (IBNR), and for the Risk Corridor, Reinsurance, and Risk Adjustment programs within the *Affordable Care Act*.

**Liabilities by OpDiv**



**Liabilities by Type  
(in Billions)**



Accrued Liabilities increased by \$11.0 billion, largely as a result of the addition of the FY 2015 liabilities related to the Reinsurance and Risk Adjustment programs associated with the *Affordable Care Act* (\$10.4 billion).

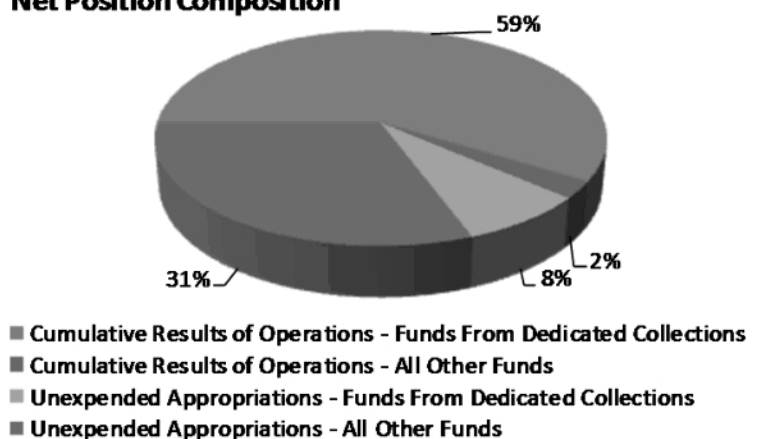
Consistent with federal accounting standards, we recognize the responsibility for future program participants of Medicare as a social insurance program, rather than a pension program. Accordingly, we have not recognized a liability for future payments to current and future program participants. The estimated long-term cost for Medicare is included in the Statement of Social Insurance and discussed later in this analysis. A more extensive discussion is provided in the "Notes to the Principal Financial Statements" located in the "Financial Section" of this report.

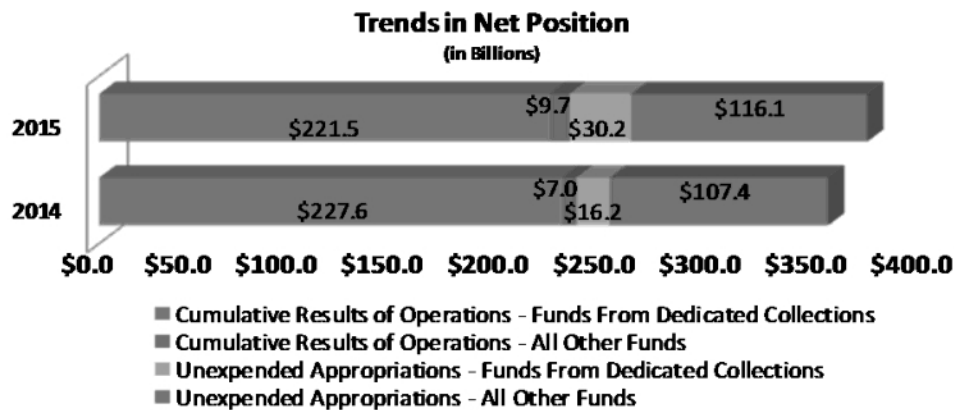
### Statement of Changes in Net Position

Our net position represents the difference between assets and liabilities. Changes in our net position result from changes that occur within the Cumulative Results of Operations and Unexpended Appropriations. Our net position increased by \$19.2 billion (5 percent), from \$358.2 billion in FY 2014 to \$377.4 billion in FY 2015.

The net position increase of \$19.2 billion is comprised of an increase in Funds From Dedicated Collections (\$251.7 billion in FY 2015 compared to \$243.8 billion in FY 2014) and an increase in All Other Funds (\$125.8 billion in FY 2015 compared to \$114.4 billion in FY 2014).

**Net Position Composition**





The significant changes within Unexpended Appropriations are primarily related to increases in Appropriations Received (\$93.9 billion) and Appropriations Used (\$80.4 billion) at CMS. These changes included an increase in Appropriations Received for Medicaid (\$78.4 billion) and Medicare (\$14.9 billion). Additionally, the OS received higher appropriations for the Community Health Center Fund and Public Health and Social Services Emergency Fund (mainly for Ebola response) for a \$2.2 billion combined increase. The increase in Appropriations Used primarily relates to an increase of \$46.1 million for Medicaid as a result of expansion associated with the *Affordable Care Act*.

### Statement of Net Cost

Our Net Cost of Operations represents the difference between the costs incurred by our programs less associated revenues. We receive the majority of our funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. Our Net Cost of Operations for the year ended September 30, 2015, totaled \$1.0 trillion.

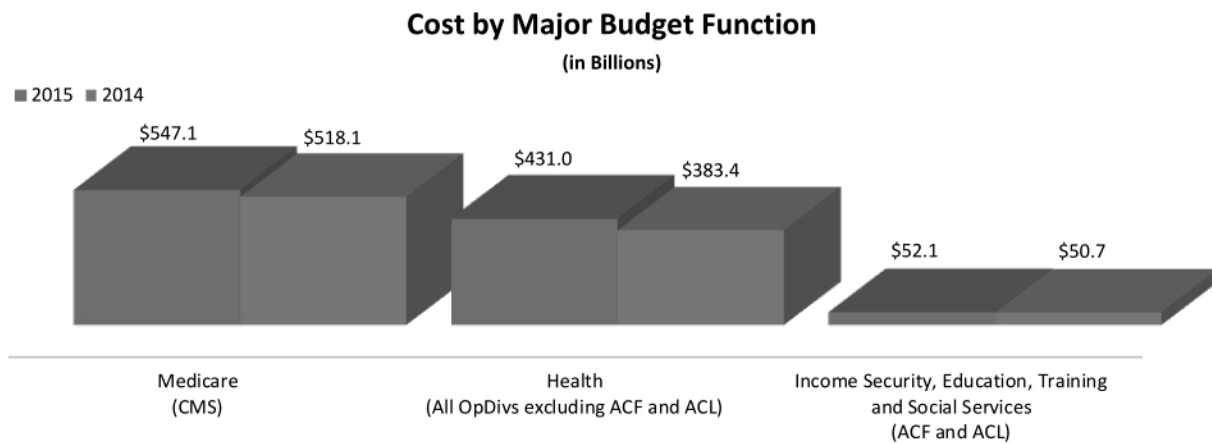
Net Cost of Operations (in Billions)			Change (2014-15)	
	2015	2014	\$	%
<b>Responsibility Segments:</b>				
CMS Gross Cost	\$1,011.3	\$910.5	\$100.8	11%
CMS Exchange Revenue	(98.0)	(73.3)	(24.7)	34%
CMS Net Cost of Operations	\$913.3	\$837.2	\$76.1	9%
<b>Other Segments:</b>				
Other Segments Gross Cost	\$120.7	\$120.5	\$0.2	0% *
Other Segments Exchange Revenue	(4.0)	(5.7)	1.7	(30)%
Other Segments Net Cost of Operations	\$116.7	\$114.8	\$1.9	2%
<b>Net Cost of Operations</b>	<b>\$1,030.0</b>	<b>\$952.0</b>	<b>\$78.0</b>	<b>8%</b>

\* Change less than 1 percent

The table above presents our FY 2015 Consolidated Net Cost of Operations by responsibility segments (OpDivs). Gross costs less exchange revenue for CMS increased by \$76.1 billion between FY 2015 and FY 2014. There was a nominal increase in total net cost of operations for the remaining HHS segments (excluding CMS) at approximately \$1.9 billion. The majority of FY 2015 net costs relate to benefit expenses for CMS's programs.

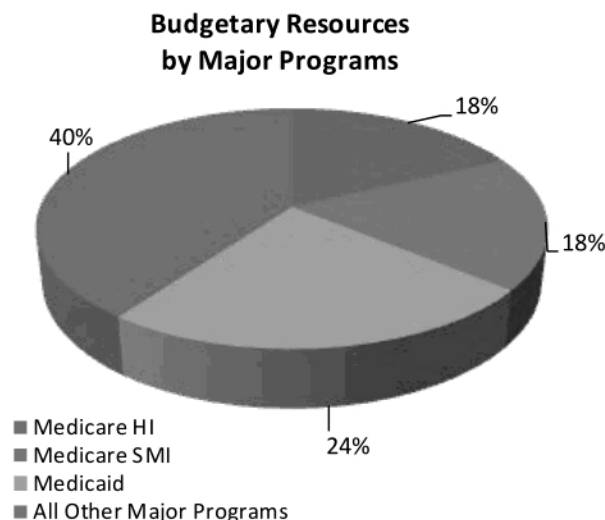


HHS classifies costs by major budget functions such as Medicare, Health, Education, and Income Security. The table below depicts consolidating costs by major budget function, comparatively between FY 2015 and FY 2014. Total costs for Medicare (\$547.1 billion) and Health (\$431.0 billion) programs account for almost 95 percent of our annual net costs. The Health budget function increased 12 percent (\$47.6 billion), primarily due to increases in Medicaid. During FY 2015, the Medicare budget function increased 6 percent (\$29.0 billion), primarily due to increases in the SMI benefit expenses and Medicare Part D administrative expenses. For more information on the budget functions, see the "Consolidating Statement of Net Cost by Budget Function" in the "Other Information" section of this report.



### Statement of Budgetary Resources

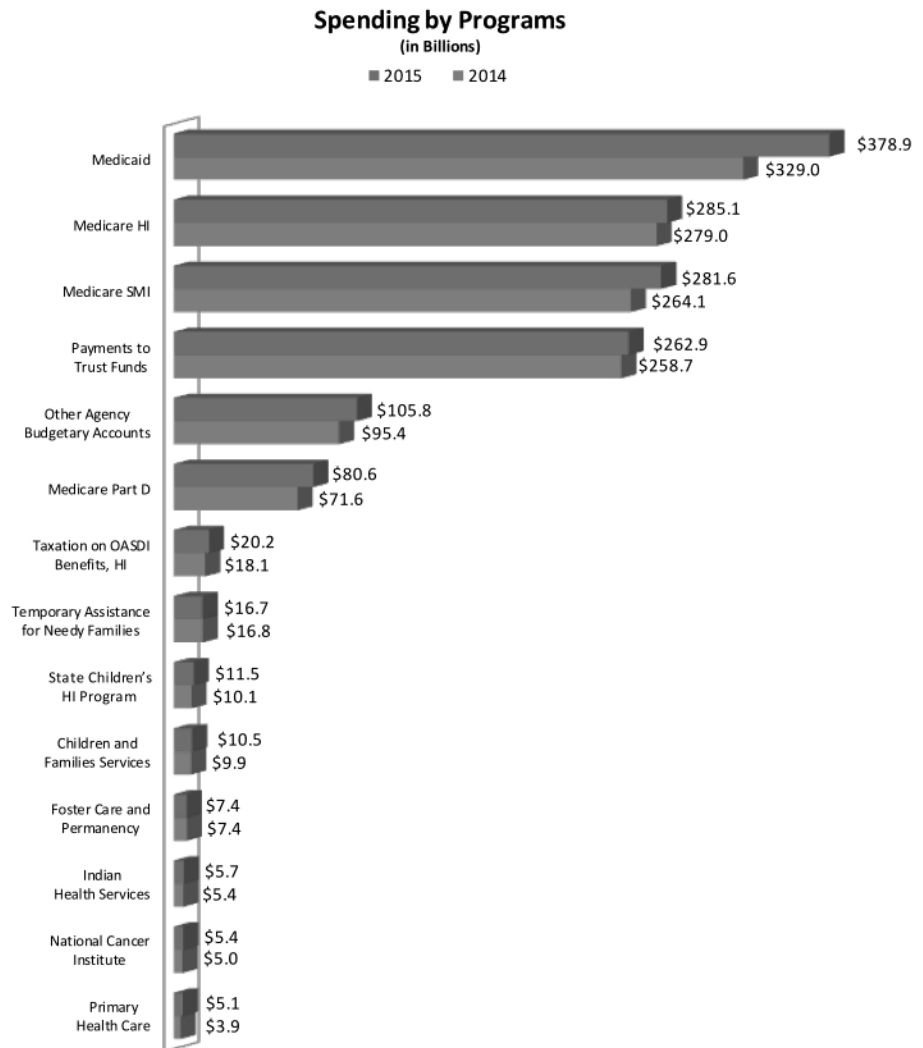
The Combined Statement of Budgetary Resources provides information on availability of budgetary and non-budgetary resources at the end of the year. FY 2015 total resources were \$1.5 trillion, representing an increase of \$130.8 billion, or 9 percent, over FY 2014. Total obligations in FY 2015 were \$1.5 trillion, an increase of \$103.1 billion, or 8 percent as compared to FY 2014. These significant changes in resources are related primarily to the increase in funding for Medicare and Medicaid programs within CMS and the appropriations for Emergency Ebola Response and Preparedness and Public Health Service Evaluation funds at CDC. The chart below shows the percentage of budgetary resources by major programs. For further details, see the "Combining Statement of Budgetary Resources" in the "Financial Section" of this report.



## Schedule of Spending

The Schedule of Spending (Note 23) presents an overview of how and where HHS has spent (obligated) money for the reporting period. The Chart to the right illustrates a summary of spending by select programs as of September 30, 2015 and 2014. Total obligations for this year were \$1.5 trillion. This is an 8 percent increase over the \$1.4 trillion in obligations for FY 2014.

Four major programs at CMS accounted for 82 percent of all HHS spending: Medicaid at 26 percent (\$378.9 billion), Medicare HI at 19 percent (\$285.1 billion), SMI at 19 percent (\$281.6 billion), and Payments to Trust Funds<sup>3</sup> at 18 percent (\$262.9 billion). The majority (91 percent) of all HHS spending was for Grants, Subsidies, and Contributions (47 percent) at \$699.1 billion and Federal Assistance Direct Payments (44 percent) at \$652.3 billion. For more information on services and items purchased, see the Combined Schedule of Spending by Object Class in the "Other Information" section of this report.



## Statement of Social Insurance

The Statement of Social Insurance presents the 75-year actuarial present value of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise for current and future program participants. This projection is considered to be important information regarding the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheets, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the Annual Report of the Medicare Board of Trustees. The basis for the projections in the Trustees Report has changed since last year

<sup>3</sup> Payments to Trust Funds include appropriations resulting from the *Social Security Act*, *Health Insurance Portability and Accountability Act of 1996* (HIPAA), and *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA) legislation to provide payments to HI and SMI trust funds.

due to the enactment of the *Medicare Access and CHIP Reauthorization Act (MACRA) of 2015*. This law repealed the sustainable growth rate (SGR) formula that set physician fee schedule payments, which were usually modified, and replaced it with specified payment updates for physicians. The projections shown in last year's Trustees report reflected a projected baseline scenario, which assumed an override of the SGR payment provisions. With the enactment of MACRA, the projections in this year's report are based on current law (for more information, see Notes 24 and 25 of the "Financial Section").

The Statement of Social Insurance presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from \$(3.8) trillion, determined as of January 1, 2014, to \$(3.2) trillion, determined as of January 1, 2015.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2015, of future cash flow for all current and future participants to \$(2.9) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is \$(8.6) trillion.

### ***HI Trust Fund Solvency***

#### **Pay-as-you-go Financing**

The HI Trust Fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI Trust Fund assets have been declining. The table below shows the HI Trust Fund assets, expressed as a ratio of the assets at the beginning of the FY to the expenditures for the year. This ratio has steadily dropped from 107 percent at the beginning of FY 2011 to 74 percent at the beginning of FY 2015.

Trust Fund Ratio Beginning of Fiscal Year					
	2011	2012	2013	2014	2015
HI	107%	95%	86%	77%	74%

### **Short-Term Financing**

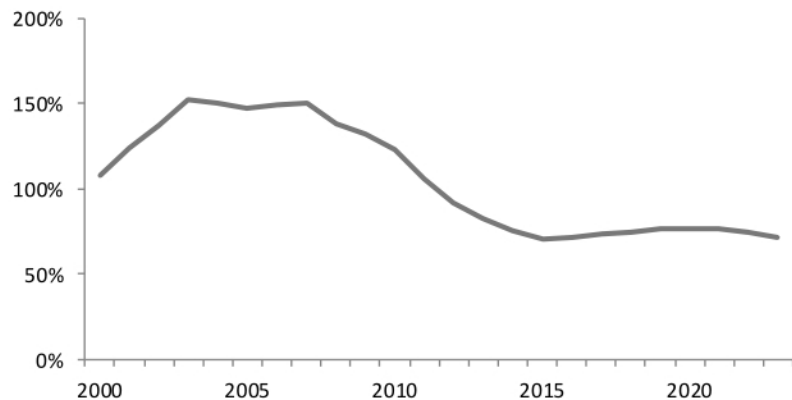
The HI Trust Fund is deemed adequately financed for the short-term when actuarial estimates of trust fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2015 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2015 Trustees Report, the HI Trust Fund ratio is estimated to continue decreasing through the beginning of 2017 and remain at approximately 70 percent through 2022. From the end of 2014 to the end of 2024, assets are expected to increase, from \$197.3 billion to \$290.0 billion.

### **Long-Term Financing**

The short-range outlook for the HI Trust Fund is about the same as projected last year. After 2022, the trust fund ratio starts to decline quickly until the fund is depleted in 2030, the same date projected last year. HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected. Program cost exceeded total income in 2014, and thereafter, income is projected to exceed costs for several years before falling below it in 2024 and later. When the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 86 percent in 2030 to 79 percent in 2039 and then to increase to about 84 percent by the end of the projection period.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of beneficiaries eligible for benefits drops from 3 percent in 2014 to about 2 percent by 2089. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is \$3.0 trillion, which is less than 1 percent of taxable payroll and Gross Domestic Product (GDP) over the same period.

**HI Trust Fund Ratio**



Significant uncertainty surrounds the estimates for the Statement of Social Insurance. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. The Trustees assume that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for all categories of Part A providers by the growth in economy-wide private nonfarm business multifactor productivity—will occur as the *Affordable Care Act* requires. The Trustees believe that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. However, if the health sector cannot transition to more efficient models of care delivery and achieve productivity increases commensurate with economy-wide productivity, and if the provider reimbursement rates paid by commercial insurers continue to follow the same negotiated process used to date, then the availability and quality of health care received by Medicare beneficiaries would, under current law, fall over time relative to that received by those with private health insurance.

### ***SMI Trust Fund Solvency***

The SMI Trust Fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI Trust Fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, Part D appropriation has generally included an indefinite authority provision allowing for amounts to be transferred to the Part D account on an as-needed basis. This provision allows previously apportioned amounts to change without additional Congressional action if those amounts are later determined to be insufficient. Consequently, once an appropriation with this provision has been made, no deficit will occur in the Part D account, and no contingency fund will be necessary to cover deficits.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is \$0. However, from a government-wide perspective, General Fund transfers as well as interest payments to the Medicare Trust Funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government-wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is \$(24.8) trillion.

Even though from a program perspective, the unfunded liability is \$0, there is concern over the rapid growth in SMI expenditures as a percent of GDP. In 2014, SMI expenditures were 2 percent of GDP. By 2089, SMI expenditures are projected to grow to 4 percent of the GDP. The table below presents key amounts from CMS's basic financial statements for FY 2013 through 2015.

**Table of Key Measures<sup>4</sup>**

<b>Financial Condition Summary (in Billions)</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>
<b>Net Position (end of fiscal year)</b>			
Assets	\$418.6	\$380.0	\$370.2
Less Total Liabilities	129.1	104.7	88.3
<b>Net Position (assets net of liabilities)</b>	<b>\$289.5</b>	<b>\$275.3</b>	<b>\$281.9</b>
<b>Change in Net Position (end of fiscal year)</b>			
Net Costs	\$913.8	\$837.8	\$779.8
Total Financing Sources	910.3	820.4	756.1
<b>Change in Net Position</b>	<b>(\$3.5)</b>	<b>(\$17.4)</b>	<b>(\$23.7)</b>
<b>Statement of Social Insurance (calendar year basis)</b>			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	(\$3,187.0)	(\$3,822.9)	(\$4,771.8)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	(\$3,822.9)	(\$4,771.8)	(\$5,581.2)
<b>Change in present value</b>	<b>\$635.9</b>	<b>\$948.9</b>	<b>\$809.4</b>

<sup>4</sup> The Table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, the CMS presents the closed group measure and open group measure.

## Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2015, would have decreased by \$202.2 billion due to advancing the valuation date by one year and including the additional year 2089, by \$82.1 billion due to changes in the projection base, and by \$35.2 billion due to the changes in demographic assumptions. However, changes in economic and health care assumptions and legislation changes increased the present value of future cash flows by \$754.6 billion and \$200.8 billion, respectively.

## Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) Number 17, *Accounting for Social Insurance* (as amended by SFFAS Number 37, *Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), CMS has included information about the Medicare trust funds – HI and SMI. The “Required Supplementary Information” section presents required long-range cash flow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the “Required Supplementary Information” section. The “Required Supplementary Information” section assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds.

## Limitation of the Principal Financial Statements

The principal financial statements in the “Financial Section” have been prepared to report our financial position and results of operations, pursuant to the requirements of 31 U.S.C. §3515(b). Although the statements have been prepared from our books and records in accordance with GAAP for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing HHS with resources and budget authority.

# Financial Section



## *About the photo*

*Secretary Burwell takes the stage at the 2015 White House Conference on Aging.*

## In This Section

- Message from the Chief Financial Officer
- Report of the Independent Auditors
- Department's Response to the Report of the Independent Auditors
- Principal Financial Statements
- Notes to the Principal Financial Statements
- Required Supplementary Stewardship Information
- Required Supplementary Information

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## MESSAGE FROM THE CHIEF FINANCIAL OFFICER



The Department of Health and Human Services (HHS or the Department) oversees one of the largest budgets in the world, managing one of every four dollars spent by the federal government. This Agency Financial Report (AFR) represents our accountability in reporting for Fiscal Year (FY) 2015. To complement the AFR, we will publish the FY 2015 *HHS Summary of Performance and Financial Information*, along with the FY 2017 *Congressional Budget Justification and Annual Performance Plan and Report* in February 2016.

The Department was recently recognized for demonstrating excellence in all aspects of accountability and transparency by the Association of Government Accountants (AGA). HHS was awarded AGA's *Certificate of Excellence in Accountability Reporting* for our FY 2014 AFR. Our Chief Financial Officer (CFO) community collaboratively manages financial accountability, transparency, compliance, and risk across the Department by prioritizing resources to drive mission results. We are dedicated to working together as a CFO community to improve Department-wide operations, financial reporting and systems, with the overall goal to consistently strengthen internal control, maintain data integrity, increase data transparency, and report reliable information on a timely basis. During FY 2015, we took on new initiatives, achieved many key milestones, and worked to address audit deficiencies. We discuss our plans for continuing to correct audit weaknesses and non-compliances in the "Management's Discussion and Analysis" section of the AFR. Examples of our drive for excellence include:

- Implementing Enterprise Risk Management (ERM) across the Department, and making great strides in developing our standard risk language and vision for the HHS ERM program. These ERM initiatives will help us better understand and mitigate risks in our operational environment.
- Upgraded 2 of 3 instances of our commercial off-the-shelf software supporting the Department's core financial system during FY 2015, with the third instance on-schedule to be upgraded in FY 2016. The upgrades are key components of the Department-wide strategy to mature our overall financial systems environment and ensure the continued reliability, availability, and security of our core financial system. We also expanded the use of business intelligence to further enhance the availability and analysis of financial management information to facilitate effective decision making.
- Established a Program Management Office (PMO) to oversee implementation of the *Digital Accountability and Transparency Act (DATA Act)*. The *DATA Act* PMO operates in partnership with Operating Divisions, Staff Divisions, and system business owners to ensure government-wide data standards, data exchange, and data reporting requirements are met and implemented. Additionally, the *DATA Act* PMO serves as the Federal Government's executing agent of the Section 5 Grants Pilot. Launched the Common Data Element Repository (CDER) Library. The CDER Library is a government-wide online, searchable repository for data standards, definitions, and context. Currently, the CDER Library can identify data elements within the universe of grant forms, as defined by the Section 5 Grants Pilot.
- Initiated the review, update, and development of HHS policies in financial management, grants, and acquisitions to ensure compliance with applicable federal regulations and guidance.
- Began the transition from Government-wide Accounting to the Central Accounting and Reporting System. This change will standardize Treasury Account Symbol formatting and allows agencies to report transactions in real-time to the U.S. Department of the Treasury.

This year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2015 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. Please refer to the "Report of the Independent Auditors," "Principal Financial Statements," and "Notes to the Principal Financial Statements," in this section for further information.

I want to thank our employees and our full range of partners for their efforts and collaboration throughout the FY. The achievements depicted in this report are a reflection of their tireless dedication to our mission and the American people. We are striving together to strengthen the Department's financial management capabilities and our stewardship of the resources entrusted to us.

/Ellen G. Murray/

Ellen G. Murray  
Assistant Secretary for Financial Resources and  
Chief Financial Officer  
November 13, 2015

**REPORT OF THE INDEPENDENT AUDITORS**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

**OFFICE OF INSPECTOR GENERAL**

WASHINGTON, DC 20201



NOV 13 2015

**TO:** The Secretary  
Through: DS \_\_\_\_\_  
COS \_\_\_\_\_  
ES \_\_\_\_\_

**FROM:** Inspector General *Daniel R. Levinson*

**SUBJECT:** OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2015 (A-17-15-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2015 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP (Ernst & Young), to audit the HHS (1) consolidated balance sheet as of September 30, 2015 and 2014, and the related consolidated statements of net cost and changes in net position; (2) the combined statement of budgetary resources for the years then ended; and (3) the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 15-02, *Audit Requirements for Federal Financial Statements*.

**Results of the Independent Audit**

Based on its audit, Ernst & Young found that the FY 2015 HHS consolidated balance sheet and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. As presented beginning in notes to the financial statements, with respect to the estimates for the statement of social insurance as of January 1, 2015 and 2014, and the related Statement of Social Insurance Amounts, HHS management noted in the financial statement footnotes the Medicare Board of Trustees'

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alternative scenario to illustrate, when possible, the potential understatement of Medicare cost and projection results. This scenario assumes that the various cost-reduction measures—the most important of which are the reduction in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the specified physician updates put in place by the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. No. 114-10)—will occur as current law requires. Also, the Medicare Board of Trustees, in its annual report to Congress, stated:

The Trustees are hopeful that U.S. health care practices are in the process of becoming more efficient as providers anticipate more modest rates of reimbursement growth, in both the public and private sectors, than those experienced in recent decades. The methodology for projecting Medicare finances assumes a substantial long-term reduction in per capita health expenditure growth rates relative to historical experience, to which the ACA's cost-reduction provisions would add substantial savings. Notwithstanding recent favorable developments, current-law projections indicate that Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation.

The range of the social insurance liability estimates in the various scenarios is significant. As a result, Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2015, 2014, 2013, 2012, and 2011, and the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014. Ernst & Young was not able to, and did not, express an opinion on the financial condition of the HHS social insurance program and related changes in that program for the specified periods.

Ernst & Young also noted two matters involving internal controls with respect to financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, Ernst & Young identified a material weakness in HHS's financial information management systems and significant deficiencies in its financial reporting systems, analyses, and oversight and financial management close and review processes:

- *Financial Information Management Systems*—Ernst & Young noted that HHS had continued to make strides to improve controls that support the information technology infrastructure and financial application system. HHS Senior Leadership established a Material Weakness Working Group to provide an enterprise-wide focus on corrective actions. This additional focus has led to remediation of a number of deficiencies related to HHS financial information systems identified in past audits. For example, Ernst & Young noted that HHS had reviewed and updated critical entity-wide governance documentation, such as authorities that allow systems to operate, plans to account for and improve system security, and plans to improve configuration management. HHS also updated application-level contingency plans and backup policies and procedures and performed testing to improve redundancy and availability of the supporting Information Technology infrastructure and financial application systems. As in previous FYs, Ernst

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& Young indicated a focused effort is still needed to completely remediate long-outstanding deficiencies to a level that supports an auditor's reliance on controls within the financial systems. Deficiencies were noted over controls related to segregation of duties, configuration management, and access to HHS financial systems. The deficiencies identified represent a material weakness in internal control.

- *Financial Reporting Systems, Analyses, and Oversight*—During the FY 2015 audit, Ernst & Young continued to note progress in certain areas to improve HHS's and its Operating Divisions' financial management processes. While progress has continued, the FY 2015 audit, as in prior years, identified internal control deficiencies in financial systems and processes for producing financial statements, including a lack of integrated financial management systems and insufficient analysis of certain accounts. Ernst & Young continued to note that HHS did not consistently perform controls to ensure that differences were properly identified, researched, and resolved in a timely manner and account balances were complete and accurate. Ernst & Young concluded that additional improvements in the financial reporting systems and processes are required. These deficiencies collectively constitute a significant deficiency in internal control.
- *Financial Management Close and Review Processes*—In FY 2015, Ernst & Young noted that the National Institutes of Health (NIH) upgraded its financial system, which required additional analysis to ensure that account balances recorded in the new system matched those shown at the U.S. Treasury. NIH also had a significant change in financial management personnel. These events caused NIH to identify account balances that did not correspond to those reported by Treasury. To correct these differences, NIH prepared and recorded a series of large manual journal entries. Ernst & Young found that NIH did not adequately research the differences or did not have sufficient support for the manual journal entries. Ernst & Young also found that for many of these manual journal entries, NIH did not follow the approval processes established by HHS. The deficiencies related to insufficient research, lack of adequate support, and not properly following HHS approval processes for manual journal entries collectively constitute a separate significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2015, HHS was not in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended, and section 6411 of ACA related to the implementation of recovery activities for the Medicare Advantage program. HHS reported improper payment error rates for its high-risk programs, except for Temporary Assistance for Needy Families (TANF). HHS believes it does not have the authority under the Social Security Act to compel the States to report error rates for TANF. One program, Medicare fee-for-service, reported an error rate of over 10 percent, a violation of IPIA. Five other high-priority programs reported error rates that did not meet their FY 2015 target error rates, another violation of IPIA. We will communicate further details on agency compliance with improper payment reporting, as required by the IPIA, later in FY 2016. In addition, HHS's management determined that it may have potential violations of certain provisions of the Anti-Deficiency Act (P.L. No. 101-508 and OMB Circular A-11) related to FY 2014 and FY 2015 obligation of funds for conference spending and a potential violation related to the appointment of a presidentially

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nominated official without the required confirmation. On the basis of the material weakness reported over Financial Information Management Systems and the significant deficiencies reported over Financial Reporting Systems, Analysis, and Oversight and the Financial Management Close and Review processes, Ernst & Young concluded that HHS also did not comply with the Federal Financial Management Improvement Act of 1996 (P.L. No. 104-208).

#### **Evaluation and Monitoring of Audit Performance**

In accordance with the requirements of OMB Bulletin 15-02, we reviewed Ernst & Young's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation, including that related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the HHS *FY 2015 Agency Financial Report*.

Ernst & Young is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996, or HHS's compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Gloria L. Jarmon, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at [Gloria.Jarmon@oig.hhs.gov](mailto:Gloria.Jarmon@oig.hhs.gov). Please refer to report number A-17-15-00001.

Attachment

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cc:

Ellen Murray  
Assistant Secretary for Financial Resources  
and Chief Financial Officer

Sheila Conley  
Deputy Assistant Secretary, Finance  
and Deputy Chief Financial Officer



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## Report of Independent Auditors

The Secretary and the Inspector General of the U.S. Department of  
Health and Human Services

### **Report on the Financial Statements**

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (HHS) as of September 30, 2015 and 2014, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to the financial statements. We were engaged to audit the statements of social insurance as of January 1, 2015, 2014, 2013, 2012, and 2011, the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014, and the related notes to these financial statements.

### ***Management's Responsibility for the Financial Statements***

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

### ***Auditor's Responsibility***

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2015, 2014, 2013, 2012, and 2011, the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*. Those standards and bulletin require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers





internal control relevant to HHS's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to these financial statements.

***Basis for Disclaimer of Opinion on the Statements of Social Insurance and the Related Changes in the Social Insurance Program***

As discussed in Note 24 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance and Supplementary Medical Insurance trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and Chip Reauthorization Act (MACRA).

As further described in Note 25 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2015, 2014, 2013, 2012, and 2011, management has assumed in the projections of the program that the various cost-reduction measures will occur as the ACA and the specified physician updates established by MACRA require. Management has developed an illustrative alternative scenario and projections intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 25, the ability of health care providers to sustain these price reductions will be challenging, as the best available



evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. For example, overriding the scheduled physician payment updates or the productivity adjustments for most providers, as was done repeatedly with the sustainable growth rate formula in the period leading up to the passage of MACRA and may be necessary in the future if cost rates prove inadequate, would lead to substantially higher costs for Medicare in the long range than those projected in this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2015, 2014, 2013, 2012, and 2011, and the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014.

***Disclaimer of Opinion on the Statements of Social Insurance and the Related Changes in the Social Insurance Program***

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the HHS social insurance program as of January 1, 2015, 2014, 2013, 2012, and 2011, and the related changes in the social insurance program for the periods ended January 1, 2015 and 2014.

***Opinion***

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HHS as of September 30, 2015 and 2014, and its net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

**Required Supplementary Information**

U.S. generally accepted accounting principles require that the Management's Discussion and Analysis, Required Supplementary Stewardship Information, and Required Supplementary Information as identified on HHS's Agency Financial Report Table of Contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Federal Accounting Standards Advisory Board which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we



obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

#### **Other Financial Information and Other Information**

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise HHS's basic financial statements. The Other Financial Information, as identified on HHS's Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the basic financial statements.

The Other Financial Information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the Other Financial Information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

The Other Information has not been subjected to the auditing procedures applied in the audit of the basic financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

#### **Other Reporting Required by Government Auditing Standards**

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 13, 2015, on our consideration of HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control over financial reporting and compliance.

*Ernst & Young LLP*

November 13, 2015



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## Report of Independent Auditors on Internal Control over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

The Secretary and the Inspector General of the  
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2015, and the related consolidated statement of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015, and have issued our report thereon dated November 13, 2015. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015.

### Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS's internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 15-02. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented,



or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit, we did identify certain deficiencies related to Financial Information Management Systems, described below, which we concluded to be a material weakness. We also identified certain deficiencies related to Financial Reporting Systems, Analyses, and Oversight, and Financial Management Close and Review Processes described below, which we concluded to be significant deficiencies.

### **Material Weakness**

#### ***Financial Information Management Systems***

The Department continued to make strides during fiscal year (FY) 2015 to improve the controls within its supporting information technology (IT) infrastructure and financial application systems. Senior leadership has established a Material Weakness Working Group (MWWG) tasked with monitoring remediation activities across all IT systems in scope of the Financial Statement Audit and Federal Information Security Management Act (FISMA). The MWWG has established an enterprise-wide focus on corrective actions that has led to the remediation of a number of deficiencies identified during past audits. The following summarizes some of the improvements achieved that resulted from this increased attention.

- Review and update of critical entity-wide governance documentation, such as System Security Plans, Configuration Management Plans and security documentation in support of system-level authority to operate
- Update of application-level contingency plans, backup policies, and procedures and the performance of testing to improve redundancy and availability of the supporting IT infrastructure and financial application systems.

While the MWWG has implemented specific action plans to decrease the number and severity of the deficiencies remaining in the significant financial systems, remediating the root cause of the deficiencies is an iterative process. A focused effort is still necessary to more completely remediate the long outstanding deficiencies in access controls, configuration management, and segregation of duties. The remaining deficiencies continue to constitute a material weakness in internal control. We grouped the deficiencies into topics and categories.

- Access controls
  - Inconsistently performing user access reviews, to monitor for access anomalies and suspicious activities



- Use of generic IDs, some with administrative access, that are not proactively monitored
- Users maintaining multiple user IDs to the application and/or users with excessive access to applications that are not commensurate with their job roles and responsibilities
- Configuration management
  - Verification that no changes were made that did not go through the change approval and management process to include proactive monitoring of changes in support of those reviews
  - Lack of automated mechanisms to support change management activities
  - Inconsistent maintenance of the application-level or database-level baseline configuration
- Segregation of duties:
  - Lack of role-based security and established policies and procedures supporting role-based security
  - Inconsistent implementation of least privileged access considerations for all users and lack of documentation for business justifications for necessary conflicts

The following is a summary of the deficiencies that we considered most critical. When assessed in aggregate, we continue to conclude they could have a material effect on the financial statements and as a result this forms the basis for our conclusion of an IT material weakness:

- Access controls – Access controls exceptions were identified across the Unified Financial Management System (UFMS); HHS Consolidated Acquisition Solution (HCAS); Grants Administration Tracking and Evaluation System (GATES); GrantSolutions; Enterprise Human Resources & Payroll (EHRP); Information for Management, Planning, Analysis, and Coordination (IMPACII); National Institutes of Health Business System (NBS); and Consolidated Financial Reporting System (CFRS) systems. Specifically, UFMS and HCAS use Oracle Grid Control audit logs to monitor user access and activity; however, the audit logs are not reviewed/monitored on a consistent basis. Additionally, UFMS has a user that has multiple user IDs within the application that is not required to accomplish organizational missions / business functions, providing them access that is not commensurate with their job roles and responsibilities. EHRP and NBS user activity is not consistently reviewed for suspicious or malicious activity. Also, we noted that UFMS, HCAS, and GATES leverage the use of shared user IDs, some with privileged access, without monitoring user activity performed when using shared IDs. Additionally, we noted UFMS has a large number of generic IDs that are active, without a business need for the generic ID. EHRP had users with excessive access within the application that did not map back to the access provision on their user access request form on file, while GATES does not have detailed user access procedures in place for program administrators governing the new user access provisioning process. Similarly, CMS did not have sufficient evidence of regular management reviews of user access at both the Medicare contractors and the Central Office for appropriateness. In addition, procedures for adding or removing users were not consistently followed.



- **Configuration management** – Configuration management exceptions were identified across the GATES, EHRP, HCAS, and UFMS systems. For EHRP, we noted that the configuration management process is currently being revamped and that configuration management plans, change control charters, and release management standard operating procedures were not developed or implemented across the span of the audit. Additionally, for EHRP and GATES, we noted that there is no automated and consistent process in place to monitor configuration changes made to the production environment. Furthermore, the EHRP and GATES applications do not maintain updated baseline configurations for all aspects of the application, to include back-end databases. Lastly, for EHRP, we found that users have access to the production environment as well as development access giving them the capability to develop and subsequently migrate code. CMS continues to experience deficiencies in the implementation and monitoring of compliance with its defined computer security policies at both the Medicare fee-for-service contractors and the Central Office. One significant CMS application did not have adequate segregation of duties as it relates to implementing new program code. Secure access configuration settings were not consistently implemented or reviewed. Several vulnerabilities related to system configurations were identified with the Central Office and Medicare fee-for-service information systems. Evidence supporting testing of claims processing software changes was not always retained.
- **Segregation of duties** – Segregation of duties (SOD) exceptions were identified across the UFMS, EHRP, and IMPACII systems. For EHRP, there is no entity-wide governance in place to establish segregation of duties for user access. Additionally, for EHRP, segregation of duties is not adequately enforced among the EHRP environments and the SOD matrix does not document the conflicting roles between the developer and system administrator roles, which would provide individuals the ability to develop code and migrate it into production. For UFMS, a listing of all users with SOD conflicts and their respective business justifications is not proactively maintained. For IMPACII, a listing of system-generated individuals and their corresponding roles in the IMPACII development, test, and production environments could not be provided by management, which could lead to excessive access for users across the different environments. CMS continues to experience difficulties in implementing its policy of least privilege access, preventing and monitoring for inconsistencies in access rights to various systems, and mitigating the potential impact on adequate segregation of duties. We found several deficiencies that may result in a potential lack of segregation of duties at both the Medicare fee-for-service contractors and across the enterprise.
- **FISMA compliance** – The security management program, as required by FISMA of 2002, and amended by the Federal Information Security Modernization Act of 2014, provides a framework to help identify security threats, assess risks continuously, determine that control objectives are appropriately designed and formulated, support the development and implementation of relevant control techniques, and apply consistent managerial oversight to support the overall effectiveness of security measures. Without a fully integrated security management program, the design and implementation of security



controls may be inadequate; user roles and responsibilities may be unclear; and management, operational, and technical controls may be inconsistently implemented. Such conditions will lead to insufficient protection of sensitive or critical resources. As part of our FY 2015 FISMA assessment, we performed our procedures at the following OpDivs: (1) Indian Health Service (IHS), (2) Administration for Children and Families, (3) National Institutes of Health (NIH), (4) Centers for Medicare & Medicaid Services (CMS), and the (5) HHS Office of the Secretary. We noted progress since the prior year procedures at some of the OpDivs; however, our procedures identified the following deficiencies across the OpDivs reviewed:

- Incident response and reporting – The Department’s HHS Computer Security Incident Response Center is either not documenting or reporting to US-CERT within the one-hour time frame required by OMB.
- Continuous monitoring – The Department does not have an effective process for managing and identifying unauthorized software on devices in the HHS environment.
- Patch management – The Department does not have an effective process for timely implementation of critical system patches.
- Contingency planning – The Department does not have an effective process for managing contingency plan documentation and performing a timely review. Additionally, the Department does not have sufficient oversight over testing of contingency plans.
- Plan of action and milestones (POA&M) – The Department’s security management has not fully implemented an effective POA&M process to ensure that all fields for each POA&M record are entered and updated on a timely basis and that all POA&M records are resolved and closed in a timely manner. Additionally, POA&M records extracted from the HHS Data Warehouse are not reconciled to OpDiv-level data.

#### **Recommendations**

HHS should continue the focus achieved in FY 2015 to remediate the remaining deficiencies. The following are some specific considerations:

- Continue to identify, assess, modify, and monitor access controls, configuration management, and segregation of duties to further enhance the security posture of all applications. Specific recommendations for the non-CMS OpDiv applications include the following:
  - For UFMS/HCAS/EHRP/NBS, monitor user activity, leveraging automated tools or mechanisms, on a consistent basis for suspicious activity





- For UFMS/HCAS/GATES, remove all generic IDs that do not have a business need or are no longer needed to be active within the system. For generic IDs that are needed to run the application, proactively monitor user activity performed when using shared generic IDs
- For UFMS, management should leverage their analysis to identify users with multiple UFMS user IDs and remove any instances of multiple user IDs that exist without documented and valid business justification
- For GATES, develop and implement detailed user access provisioning procedures so that leadership can leverage documented procedures when approving new user access, while attempting to prevent unauthorized or excessive access
- For EHRP, develop and finalize all entity-wide configuration management plans and charters to efficiently manage the application's configuration management process
- For EHRP/GATES, develop and implement processes to monitor the production environment to detect configuration changes made to the system and verify if these changes were implemented in accordance with the established configuration management policies and procedures
- For EHRP/GATES, define and document baseline security configurations and ensure the system configuration settings are finalized and mirror the current operational environment
- For EHRP, remove excessive access allowing users with the ability to develop code and subsequently migrate that code into the production environment
- For EHRP, system ownership should collaborate with the individual HR Centers and security and administration resources to further refine the SOD Matrix (i.e., document functional roles, system roles, and conflicting access and functions) based on all applicable roles within the system
- For UFMS, implement standardized and centralized segregation of duties policies across all the OpDivs, perform and monitor mitigation testing, and monitor the SOD reviews for each of the OpDivs to ensure that they are being performed and all SOD conflicts are resolved or justified
- For EHRP, management should develop and document procedures to implement controls for identifying, documenting, and monitoring segregation of duties conflicts within the change management process
- Throughout the course of this year's audit, we noted that GATES is going to be retired in the near future and replaced by other internal systems or other Governmental centers of



excellence. However, a focused effort should still be made to remediate weaknesses identified across all systems currently in operation, including systems that will be retired in the coming years, so as to mitigate risk and exposure to exploitation.

- We have performed a separate financial statement audit of CMS for FY 2015 and in conjunction with our reports on that audit have provided recommendations specific to CMS on our IT internal control findings. Those findings and recommendations were considered in our overall HHS conclusions.

### **Significant Deficiencies**

#### ***Financial Reporting Systems, Analysis, and Oversight***

Although progress in certain areas has been identified, HHS and its OpDivs' internal reviews and the results of our testing of internal control continued to identify internal control deficiencies in financial systems and processes for producing financial statements, including lack of integrated financial management systems and insufficient analysis of certain significant accounts. In many cases, processes continued to be developed throughout FY 2015 and will require additional refinements in FY 2016 and beyond. Within the context of the approximately \$1 trillion in departmental net outlays, the ultimate resolution of our specific 2015 findings was not material to the financial statements taken as a whole. However, these matters are indicative of systemic issues that should continue to be resolved.

#### ***Lack of Integrated Financial Management System***

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems and compliance with the United States Standard General Ledger at the transaction level and applicable federal accounting standards. Over the past 18 years, HHS has continued its efforts to overcome certain issues that have affected its ability to become compliant with the FFMIA, including the following long-standing issues, for which HHS and the audit continue to identify:

- The recording of billions of dollars in manual journal entries to ensure balances within financial systems are correct
- Departures from requirements specified in OMB A-123 Appendix D, *Management's Responsibility for Internal Control in Federal Agencies*, and OMB A-130, *Management of Federal Information Resources*, related to access and change management controls within financial systems, as discussed above
- The lack of sufficient integration within the various financial systems which are not complemented with sufficient manual preventative and detective-type controls, including



CMS' durable medical equipment (DME) Medicare Administrative Contractors (MACs) who have not fully implemented CMS' Healthcare Integrated General Ledger Accounting System and the NIH Business System which continues to have certain transactions which are captured inconsistently to the Treasury United States Standard General Ledger at the transaction level and requires adjustments to the accounting records

- Inconsistencies across the various accounting centers and financial systems on how accounting transactions are captured and which standard general ledger accounts are utilized.

Resource limitations and other priorities have consistently been identified as the causes for delays in upgrading certain system and financial internal control processes limiting HHS's ability to comply with requirements under FFMIA.

With the passage of new laws, including the Digital Accountability and Transparency Act (the DATA Act), the continued implementation of Treasury requirements, and upgrades to its financial management systems, HHS has made progress in addressing its compliance with the FFMIA. During FY 2015, the Department has moved forward in its planning and implementation of upgrades to its financial systems, expected to be completed by FY 2016; prioritized and centralized additional resources in addressing certain issues related to controls within its financial information management systems; updated various sections of departmental financial management policies; and continued to automate the manual journal entry processes required to ensure financial data is accurate.

As it continues its pursuit in resolving these long-standing issues, HHS needs to be vigilant in developing, maintaining, and implementing consistent policies and procedures, monitoring the implementation of its upgrades, providing extensive training throughout the Department to ensure consistent application, and enhancing its monitoring program to ensure continued compliance.

#### ***Financial Analysis and Oversight***

Because deficiencies continue to exist in the financial management systems, management must compensate for the deficiencies by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of deficiencies that impact HHS's ability to report accurate financial information on a timely basis. Consistent with prior years, we found that certain controls were not consistently performed to ensure that differences were properly identified, researched, and resolved in a timely manner and that account balances were complete and accurate. We identified the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required:



#### *Department/Operating Division Periodic Analysis and Reconciliation*

As deficiencies exist in financial systems, management compensates by implementing and strengthening other manual controls to ensure that errors and irregularities are prevented or detected in a timely manner. These manual and compensating controls may include monitoring of budgets, reconciliations of accounts, analyses of fluctuations, aging of accounts, and manual and supervisory reviews. During our audit, we found that certain controls still required further improvements. The following represent specific areas that need enhanced periodic reconciliation and analysis:

- *Departmental Review of OpDivs Financial Statements and Other Financial Activity* – The Department performs periodic reviews of OpDivs' financial activity as part of the financial reporting process and for external inquiry purposes. However, we noted that further improvements are necessary at the OpDiv level in performing analysis of its financial data and amounts and communication of newly adopted, unique and/or complex financial management activities to the Department. We observed significant improvements from prior years with the identification by the Department's Office of Finance of significant discrepancies through its implementation of new analysis tools. However, NIH and CMS failed to communicate certain significant or complex activities that were material to the Department in a timely fashion.
- *Fund Balance with Treasury* – Every month, HHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of September 30, 2015, the general ledger and Treasury's records differed by more than an approximate absolute value of \$1.4 billion. This primarily relates to differences that were either timing differences or differences that were not adequately researched and cleared from the suspense accounts. Additionally, differences in HHS suspense account reconciliations were not properly cleared within the 60 days required time frame. For example, based on the support provided, the Out of Balance report for NIH which supports its Fund Balance with Treasury reconciliation had outstanding items from FY 2008 to FY 2015, which indicated that differences are not being resolved in a timely manner (i.e., within the required 60 days). Many of the stale differences presented on the Out of Balance report were carried over from the previous financial systems upgrade. As of June 2015, there was a net difference of \$0.9 billion with an absolute variance of \$1.8 billion. Finally, we identified several Fund Balance with Treasury reconciliations prepared in the Indian Health Service area offices, which were either not reviewed or were improperly prepared.
- *Property, Plant, and Equipment* – We found that sufficient documentation was not readily available to support certain amounts and disclosures related to property, plant, and equipment. For example, the following:
  - Certain assets at the Indian Health Service were purchased in prior years and put into service, but were not recorded to accounting records until FY 2015.



- For two of six NIH selected samples, we were not able to agree invoices to the amounts identified in NIH's property subsidiary ledger. We were informed that adjustments to amounts had recently been requested.
- *Commissioned Corp* – During January 2014, HHS transferred the Commissioned Corp retiree, annuitant and surviving payroll processes from a commercial financial shared service center to the US Coast Guard. During FY 2015, we determined that reviews of the respective Coast Guard internal control systems had not sufficiently taken place during the fiscal year nor had sufficient communications taken place to ensure timely access of Commission Corp data or documentation for audit purposes. We have been informed that the active processes will also be transferred from the commercial financial shared service center to Coast Guard in January 2016. In preparation for the move, improvements in the agreements between the two agencies are necessary to ensure a system's assessment would be available in FY 2016 and that documentation to support Commissioned Corp payroll – at the individual level – would be available more timely.

#### *Policies and Procedures*

During FYs 2014 and 2015, the Department initiated a plan to upgrade its policies and procedures, including hiring of new personnel to oversee the process, setting up formal prioritized processes from initiation to implementation, defining required levels of approvers, and holding meetings and review periods with OpDivs to ensure input and collaboration into the finalization and implementation of the policy. Many proposed policies were implemented during FY 2015. With certain policies requiring updating, laws being passed and requiring implementation, and as internal control processes change, the Department has not completed its updating of procedural manuals to ensure that sufficient knowledge of financial management systems/processes or consistency and adequacy of internal control exist. For example, HHS management indicated that, while certain policies within its procedural manuals have been drafted awaiting final approval, including sections within its accounting treatment manual, others continue to be on a listing waiting to be updated or approved.

Further, as part of the accounting centers' monthly processes, the Department has instituted a policy whereby the accounting centers certify the status of completing required periodic reconciliations. For each required reconciliation, the preparers and approvers are required to sign off and provide a date of completion. On a monthly basis, the document is forwarded to the Department. Other than the detailed data submitted through CFRS, no supporting documentation is required to be provided as part of the submission. We observed in FY 2015 that follow-up requests from the Department to the OpDivs took place when discrepancies were identified; however, our review of the OpDivs' submissions and the supporting documentation maintained at the OpDivs identified inconsistencies in the procedures performed, the reports utilized, and the results provided among the various OpDivs. Additionally, we noted that although the financial statements are submitted to OMB on the 21st day after the end of the quarter, the Department's policy did not require reconciliations to be completed and certified until the end of the month.



#### *Financial Management Controls at CMS*

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on its internal controls dated November 9, 2015. In that report, we outlined details of deficiencies noted and made recommendations for improvement in its financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies and those related to business partner risk management, noted elsewhere in this report, to be a significant deficiency for the CMS internal control over financial reporting.

Our observations related to financial management controls included a recommendation that as CMS continues to enhance its data analyses capability, further improvement can be made by developing robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. To the extent more robust analysis occurs within Centers and Offices, identifying, evaluating, and reviewing such analysis would assist in ensuring that a perspective that incorporates a financial reporting point of view is captured and considered. It may be beneficial for CMS to identify a cross-functional working group to perform such analysis.

#### *Business Partner Risk Management at CMS*

CMS relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Medicare Part C and Part D programs. We identified areas where improvements could be made in the control environment related to the oversight of third-party contractors.

The contracts between CMS and its Medicare fee-for-service contractors include provisions that require the MACs to develop and follow objectives established by CMS. Through the established procedures, CMS monitors the MACs' compliance with its policies and procedures, established internal controls and the completeness and accuracy of financial reporting. While this approach to financial integrity supports monitoring of the MACs' financial controls, the oversight/monitoring process historically has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that the issues are timely remediated by the MACs.

As noted in the prior year, we identified deficiencies where actions are required but have not been taken or resolved in the following circumstances: (1) the Medicare Summary Notices, which are returned to the MACs but are not investigated as to why they are returned; (2) the claims outstanding greater than one year – periodic review, track or monitor those aged claims other than those identified as bankruptcy, fraud or abuse; and (3) the provider records – reconcile, review or monitor provider records and provider eligibility status on a periodic basis to verify that all changes were timely, accurately, and completely processed.



### Recommendations

We recommend that HHS continue to develop, refine and adhere to its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. Specifically, we recommend that HHS perform the following:

- Continue to move forward in its planning and implementation to upgrade its financial systems; prioritize and centralize additional resources in addressing certain issues related to controls within its financial information management systems; and continue to automate the manual journal entry processes required to ensure financial data is accurate.
- Continue to focus on reducing the number of manual journal vouchers by determining the cause and the ability to upgrade systems to allow for automated posting of certain high-volume routine transactions.
- Continue to update and implement the Department-wide policies and procedures and other guidance to enable the collection of consistent financial data and consistency in the processing of financial activity among its accounting centers and headquarters. As policies and procedures are developed, training should be developed and delivered across all OpDivs to determine consistent application of the new policies. Additionally, ongoing monitoring processes should be enhanced to ensure appropriateness and consistency over the long-term and continued compliance.
- Develop increased communication protocols with all OpDivs, especially CMS and NIH, to enhance notification and awareness of newly adopted, unique and/or complex financial management activity for purposes that may impact the Department's required financial reporting.
- Strengthen policy and controls surrounding the property, plant, and equipment and related processes to ensure that documentation is maintained and that balances are accurate and supportable.
- Strengthen the agreement between HHS and the Coast Guard to provide for a system's assessment in FY 2016 and that documentation to support Commissioned Corp payroll – at the individual level – would be available more timely.
- Strengthen controls surrounding Fund Balance with Treasury reconciliations to ensure differences are remediated properly and timely. HHS should develop and monitor processes to ensure suspense account transactions are cleared properly on a timely basis.
- Establish a policy individual or group to analyze the accounting and reporting of unique, newly implemented, non-routine, or significant transactions; enhance the financial reporting process; and address or identify transactions that required cross-functional input. Enhancement of this process may assist to develop, document, and validate the new critical accounting matters that are identified or implemented during the year and



improve the timeliness and completeness of the white papers. In addition, prepare the required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders.

Additionally, we recommend that CMS continue to develop and refine its financial management controls and business partner risk management as a means to improve its accounting, analysis, and oversight of financial management activity. More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

#### ***Financial Management Close and Review Processes***

In FY 2015, the NIH upgraded its General Ledger system to Oracle R12; partially implemented of the HHS Accounting Treatment Manual, performed additional analysis of its balances and transactions in order to report budgetary activity through the Government-wide Treasury Account Symbol Adjusted Trial Balance System (GTAS); and underwent a significant change in financial accounting personnel. The convergence of these events caused NIH to find a series of general ledger balances related to Treasury and budgetary activity from current and prior years that did not agree with the corresponding GTAS balances. The process to correct these balances included a series of large dollar balance journal entries. Our analysis of those entries did not cause us to change our opinion on the FY 2015 financial statements of HHS taken as a whole. However, we did find that the research of the differences was inadequate, the supporting documentation underlying the journal entries was insufficient, and the HHS journal entry approval processes were not followed.

#### **Recommendation**

The analyses prepared for the audit should be formalized and made a part of the accounting records of NIH. In addition, the analysis and adjustment processes related to balances at NIH should be revised to assure differences are thoroughly researched and adjustments are properly documented and approved. Finally, HHS should continue to perform intensified analyses of balances at all other OpDivs while undergoing the Oracle R12 upgrades.





### *Status of Prior Year Findings*

In the reports on the results of the FY 2014 audit of the HHS financial statements, a number of issues were raised relating to internal control over financial reporting. The chart below summarizes the current status of the prior year items:

Material Weakness		
Issue Area	Summary Control Issue	FY 2015 Status
Financial Management Information Systems	<ul style="list-style-type: none"> <li>• Segregation of Duties</li> <li>• Change Management</li> <li>• Access Controls</li> <li>• FISMA Compliance</li> </ul>	Certain progress noted; certain issues need continued focus  Modified Repeat Condition
Significant Deficiency		
Financial Reporting Systems, Analyses, and Oversight	<ul style="list-style-type: none"> <li>• Lack of Integrated Financial Management System</li> <li>• Financial Analysis and Oversight</li> </ul>	Progress noted; however, certain issues identified require continued focus. Modified Repeat Condition

### **HHS's Response to Findings**

HHS's response to the findings identified in our audit is included in its letter dated November 13, 2015, which has been included at the end of this report. HHS's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

### **Purpose of This Report**

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing, and not to provide an opinion on the entity's internal control. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control. Accordingly, this communication is not suitable for any other purpose.

November 13, 2015



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## Report of Independent Auditors on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance With *Government Auditing Standards*

The Secretary and the Inspector General of the  
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the Office of Management and Budget (OMB) Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Department of Health and Human Services (HHS), which comprise the consolidated balance sheet as of September 30, 2015, and the related consolidated statement of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015, and have issued our report thereon dated November 13, 2015. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015.

### Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, non-compliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 15-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA) (P.L.104-208). However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to HHS.



The results of our tests of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of non-compliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 15-02, and which are described below.

During fiscal year (FY) 2015, HHS's management determined that it may have potential violations of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to FY 2014 and FY 2015 obligation of funds for conference spending and a potential violation related to the appointment of a Presidentially nominated official without the required confirmation.

The Improper Payments Information Act of 2002 (P.L. 107-300) as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 (P.L. 111-204) and the Improper Payments Elimination and Recovery Improvement Act of 2014 (P.L. 112-248) (hereinafter, the "Acts") require federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. While it continues to make progress, HHS is currently not in full compliance with the requirements of the Acts. For example, HHS has reported error rates for each of its high-risk programs except for the Temporary Assistance for Needy Families (TANF). HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement for TANF due to Section 411 of the Social Security Act, which specifies the data elements that HHS may require states to report, and Section 417 of the same Social Security Act, which dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS's position is that it does not have the authority to collect data pertaining to case and payment accuracy for TANF since the information is not included under the Social Security Act. Additionally, we noted certain high risk programs that did not meet their identified targets or exceeded the maximum 10% threshold stipulated by the Acts. Also, HHS is not in full compliance with Section 6411 of the Patient Protection and Affordable Care Act, as HHS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program. To date, HHS posted a Request for Quote in June 2014; however, no responses were received but HHS anticipates executing a contract in FY 2016.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed instances in which HHS's financial management systems did not substantially comply with certain requirements as discussed above. We have identified the following instances of non-compliance related to FFMIA:

- During FY 2015, thousands of manual journal vouchers were required to be recorded in the Unified Financial Management System (UFMS)/National Institutes of Health Business System (NBS) to post certain types of transactions not currently configured



correctly within UFMS/NBS and for the purpose of ensuring that balances within financial systems are correct to enable the development of periodic financial statements.

- Although progress was noted, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB A-130, *Management of Federal Information Resources*, and OMB A-123 Appendix D, *Management's Responsibility for Internal Control in Federal Agencies*. Additionally, the Office of Inspector General (OIG) identified certain issues, including access control deficiencies related to systems as part of its Federal Information Security Management Act and other OIG engagements. Finally, HHS management has identified certain weaknesses within its information technology general and application controls during its assessment of corrective action status and its OMB A-123 processes.
- The lack of sufficient integration within the various financial systems are not complemented with sufficient manual preventative and detective type controls, including Centers for Medicare & Medicaid Services' (CMS') durable medical equipment Medicare Administrative Contractors who have not fully implemented CMS' Healthcare Integrated General Ledger Accounting System and the NBS which continues to have certain transactions which are recorded incorrectly at the entry point as compared to the Treasury Standard General Ledger at the transaction level and require adjustments to the accounting records.
- Inconsistencies were identified across the various accounting centers and financial systems on how accounting transactions are captured and which standard general ledger accounts are utilized.

\* \* \* \* \*

### **HHS's Response to Findings**

Our Report on Internal Control dated November 13, 2015, includes additional information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the non-compliance to FFMIA, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented and that relevant comments from HHS's management responsible for addressing the non-compliance are provided in its letter dated November 13, 2015. We did not audit management's comments, and accordingly, we express no opinion on them. Additionally, HHS is updating its Department-wide corrective action plan to address FFMIA and other financial management issues.

**Purpose of This Report**

The purpose of this report is solely to describe the scope of our testing of compliance and the results of that testing, and not to provide an opinion on HHS's compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's compliance. Accordingly, this communication is not suitable for any other purpose.

*Ernst & Young LLP*

November 13, 2015

**DEPARTMENT'S RESPONSE TO THE REPORT OF THE INDEPENDENT AUDITORS**

DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: Ellen G. Murray, Assistant Secretary for Financial Resources and Chief Financial Officer

Subject: FY 2015 Financial Statement Audit

We appreciate the opportunity to comment on the Independent Auditor's Report concerning the audit of our FY 2015 financial statements. We generally concur with the findings identified in the Report on Internal Control. The final reports are included in our FY 2015 Agency Financial Report. In response to your reports, we will prepare and update corrective action plans to address the identified audit findings. HHS leadership is dedicated to effectively resolving our challenges.

The size and complexity of our information technology (IT) environment continues to pose substantial challenges as we address weaknesses across multiple systems, organizations, and business processes. A more strategic and focused approach to strengthening controls and security over our financial systems environment was initiated in FY 2015. The Chief Financial Officer and Chief Information Officer communities formed an IT Material Weakness Working Group to more effectively identify key risks, develop effective risk responses, and implement timely corrective actions to address the material weakness. Also we are nearing completion of the migration of our financial reporting systems to the latest software. This migration is expected to provide improved security, as well as faster access to data, and simplified report queries for systems users.

The prioritization of specific internal control activities will advance our progress toward resolution of the financial reporting significant deficiency identified in the auditor's report. With the strategic direction of the HHS Risk Management and Financial Oversight Board, our stakeholders have committed to strengthening financial management controls.

HHS remains committed to ensuring sound financial management that delivers reliable and actionable information for both internal and external decision makers and stakeholders.

We would like to thank the Office of Inspector General (OIG) and our independent auditors, Ernst & Young LLP, for your efforts on our behalf. We appreciate the continued collaboration of the OIG to improve our stewardship and transparency of taxpayer funds.

/Ellen G. Murray/

Ellen G. Murray  
Assistant Secretary for Financial Resources and  
Chief Financial Officer  
November 13, 2015

## PRINCIPAL FINANCIAL STATEMENTS

### U.S. Department of Health and Human Services

#### Consolidated Balance Sheets

As of September 30, 2015 and 2014

(in Millions)

	2015	2014
<b>Assets (Note 2)</b>		
<b>Intragovernmental Assets</b>		
Fund Balance with Treasury (Note 3)	\$ 219,459	\$ 176,958
Investments, Net (Note 4)	269,651	278,900
Accounts Receivable, Net (Note 5)	1,005	919
Other Assets (Note 8)	178	95
<b>Total Intragovernmental Assets</b>	<b>490,293</b>	<b>456,872</b>
Accounts Receivable, Net (Note 5)	21,915	10,159
Inventory and Related Property, Net (Note 6)	9,516	8,606
General Property, Plant and Equipment, Net (Note 7)	5,917	5,868
Other Assets (Note 8)	1,154	810
<b>Total Assets</b>	<b>\$ 528,795</b>	<b>\$ 482,315</b>
<b>Stewardship Land (Notes 1 and 20)</b>		
<b>Liabilities (Note 9)</b>		
<b>Intragovernmental Liabilities</b>		
Accounts Payable	\$ 309	\$ 401
Other Liabilities (Note 13)	3,609	3,022
<b>Total Intragovernmental Liabilities</b>	<b>3,918</b>	<b>3,423</b>
Accounts Payable	574	555
Entitlement Benefits Due and Payable (Note 10)	108,149	91,037
Accrued Liabilities (Note 12)	14,250	3,314
Federal Employee and Veterans' Benefits (Note 11)	12,072	11,979
Contingencies and Commitments (Note 14)	9,105	11,332
Other Liabilities (Note 13)	3,320	2,501
<b>Total Liabilities</b>	<b>151,388</b>	<b>124,141</b>
<b>Net Position</b>		
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	30,184	16,215
Unexpended Appropriations - All Other Funds	116,089	107,427
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	221,480	227,551
Cumulative Results of Operations - All Other Funds	9,654	6,981
<b>Total Funds from Dedicated Collections</b>	<b>251,664</b>	<b>243,766</b>
<b>Total All Other Funds</b>	<b>125,743</b>	<b>114,408</b>
<b>Total Net Position</b>	<b>377,407</b>	<b>358,174</b>
<b>Total Liabilities and Net Position</b>	<b>\$ 528,795</b>	<b>\$ 482,315</b>

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

**U.S. Department of Health and Human Services**  
**Consolidated Statement of Net Cost**  
For the Years Ended September 30, 2015 and 2014  
(in Millions)

	2015	2014
<b>Responsibility Segments</b>		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	\$ 1,011,350	\$ 910,511
Exchange Revenue	(98,030)	(73,276)
CMS Net Cost of Operations	913,320	837,235
Other Segments:		
Administration for Children and Families (ACF)	50,300	49,283
Administration for Community Living (ACL)	1,755	1,485
Agency for Healthcare Research and Quality (AHRQ)	359	386
Centers for Disease Control and Prevention (CDC)	10,517	10,336
Food and Drug Administration (FDA)	4,225	3,833
Health Resources and Services Administration (HRSA)	9,158	8,817
Indian Health Service (IHS)	6,158	6,339
National Institutes of Health (NIH)	29,985	30,676
Office of the Secretary (OS)	3,174	4,209
Program Support Center (PSC)	1,942	1,784
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,391	3,275
Other Segments Gross Cost of Operations before Actuarial Gains and Losses	\$ 120,964	\$ 120,423
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan (Note 11)	(249)	82
Other Segments Gross Cost of Operations after Actuarial Gains and Losses	\$ 120,715	\$ 120,505
Exchange Revenue	(4,006)	(5,758)
Other Segments Net Cost of Operations	116,709	114,747
<b>Net Cost of Operations (Note 15)</b>	<b>\$ 1,030,029</b>	<b>\$ 951,982</b>

*The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.*



**U.S. Department of Health and Human Services**  
**Consolidated Statement of Changes in Net Position**

For the Year Ended September 30, 2015  
(in Millions)

	2015			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
<b>Cumulative Results of Operations:</b>				
Beginning Balances	\$ 227,551	\$ 6,981	\$ -	\$ 234,532
<b>Budgetary Financing Sources:</b>				
Other Adjustments (Rescissions, etc.) (+/-)	-	(746)	-	(746)
Appropriations Used	295,986	478,803	-	774,789
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	237,972	-	-	237,972
Non-exchange Revenue - Investment Revenue	10,854	5	-	10,859
Non-exchange Revenue - Other	3,557	-	-	3,557
Donations and Forfeitures of Cash and Cash Equivalents	75	-	-	75
Transfers-in/out without Reimbursement	(4,673)	3,467	-	(1,206)
Other (+/-)	-	(1)	-	(1)
<b>Other Financing Sources (Non-Exchange):</b>				
Donations and Forfeitures of Property	-	10	-	10
Transfers-in/out Without Reimbursement (+/-)	(6)	(8)	-	(14)
Imputed Financing	30	668	(204)	494
Other (+/-)	1	841	-	842
Total Financing Sources	543,796	483,039	(204)	1,026,631
Net Cost of Operations (+/-)	549,867	480,366	(204)	1,030,029
Net Change	(6,071)	2,673	-	(3,398)
<b>Cumulative Results of Operations:</b>	<b>\$ 221,480</b>	<b>\$ 9,654</b>	<b>\$ -</b>	<b>\$ 231,134</b>
<b>Unexpended Appropriations:</b>				
Beginning Balances	\$ 16,215	\$ 107,427	\$ -	\$ 123,642
<b>Budgetary Financing Sources:</b>				
Appropriations Received	288,636	542,401	-	831,037
Appropriations Transferred in/out	-	387	-	387
Other Adjustments	21,319	(55,323)	-	(34,004)
Appropriations Used	(295,986)	(478,803)	-	(774,789)
Total Budgetary Financing Sources	13,969	8,662	-	22,631
Total Unexpended Appropriations	30,184	116,089	-	146,273
<b>Net Position</b>	<b>\$ 251,664</b>	<b>\$ 125,743</b>	<b>\$ -</b>	<b>\$ 377,407</b>

*The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.*

**U.S. Department of Health and Human Services**  
**Consolidated Statement of Changes in Net Position**  
For the Year Ended September 30, 2014  
(in Millions)

	2014			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
<b>Cumulative Results of Operations:</b>				
Beginning Balances	\$ 243,996	\$ 8,553	\$ -	\$ 252,549
<b>Budgetary Financing Sources:</b>				
Other Adjustments (Rescissions, etc.) (+/-)	-	(573)	-	(573)
Appropriations Used	260,360	432,855	-	693,215
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	227,822	-	-	227,822
Non-exchange Revenue - Investment Revenue	11,360	3	-	11,363
Non-exchange Revenue - Other	3,826	-	-	3,826
Donations and Forfeitures of Cash and Cash Equivalents	63	-	-	63
Transfers-in/out without Reimbursement	(3,389)	2,083	-	(1,306)
Other (+/-)	-	-	-	-
<b>Other Financing Sources (Non-Exchange):</b>				
Donations and Forfeitures of Property	-	53	-	53
Transfers-in/out Without Reimbursement (+/-)	(4)	(1)	-	(5)
Imputed Financing	37	711	(194)	554
Other (+/-)	-	(1,047)	-	(1,047)
Total Financing Sources	500,075	434,084	(194)	933,965
Net Cost of Operations (+/-)	516,520	435,656	(194)	951,982
Net Change	(16,445)	(1,572)	-	(18,017)
<b>Cumulative Results of Operations:</b>	<b>\$ 227,551</b>	<b>\$ 6,981</b>	<b>\$ -</b>	<b>\$ 234,532</b>
<b>Unexpended Appropriations:</b>				
Beginning Balances	\$ 4,469	\$ 105,728	\$ -	\$ 110,197
<b>Budgetary Financing Sources:</b>				
Appropriations Received	273,772	458,633	-	732,405
Appropriations Transferred in/out	-	(4)	-	(4)
Other Adjustments	(1,666)	(24,075)	-	(25,741)
Appropriations Used	(260,360)	(432,855)	-	(693,215)
Total Budgetary Financing Sources	11,746	1,699	-	13,445
Total Unexpended Appropriations	16,215	107,427	-	123,642
<b>Net Position</b>	<b>\$ 243,766</b>	<b>\$ 114,408</b>	<b>\$ -</b>	<b>\$ 358,174</b>

*The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.*

**U.S. Department of Health and Human Services**  
**Combined Statement of Budgetary Resources**  
For the Years Ended September 30, 2015 and 2014  
(in Millions)

	2015		2014	
	Budgetary	Non-Budgetary Credit Reform Financing Account	Budgetary	Non-Budgetary Credit Reform Financing Account
<b>Budgetary Resources:</b>				
Unobligated Balance, Brought Forward, Oct 1	\$ 37,878	\$ 3	\$ 41,577	\$ 111
Recoveries of Prior Year Unpaid Obligations	26,380	-	26,083	-
Other Changes in Unobligated Balance	20,176	-	(719)	(62)
Unobligated Balance from Prior Year Budget Authority, Net	84,434	3	66,941	49
Appropriations (Discretionary and Mandatory)	1,425,607	-	1,320,180	(4)
Borrowing Authority (Discretionary and Mandatory)	-	50	-	237
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	32,931	80	24,658	198
<b>Total Budgetary Resources (Note 23)</b>	<b>\$ 1,542,972</b>	<b>\$ 133</b>	<b>\$ 1,411,779</b>	<b>\$ 480</b>
<b>Status of Budgetary Resources:</b>				
Obligations Incurred (Notes 18 and 23)	\$ 1,477,350	\$ 131	\$ 1,373,901	\$ 477
Unobligated Balance, End of Year:				
Apportioned	26,449	-	29,384	-
Exempt from Apportionment (Note 16)	(2,621)	-	39	-
Unapportioned	41,794	2	8,455	3
Total Unobligated Balance, End of Year	65,622	2	37,878	3
<b>Total Budgetary Resources (Note 23)</b>	<b>\$ 1,542,972</b>	<b>\$ 133</b>	<b>\$ 1,411,779</b>	<b>\$ 480</b>
<b>Change in Obligated Balance:</b>				
<b>Unpaid Obligations:</b>				
Unpaid Obligations, Brought Forward, Oct 1	\$ 216,166	\$ 998	\$ 188,654	\$ 1,248
Obligations Incurred (Notes 18 and 23)	1,477,350	131	1,373,901	477
Outlays (Gross)	(1,430,984)	(754)	(1,320,306)	(727)
Actual Transfers, unpaid obligations	196	-	-	-
Recoveries of Prior Year Unpaid Obligations	(26,380)	-	(26,083)	-
<b>Unpaid Obligations, End of Year</b>	<b>\$ 236,348</b>	<b>\$ 375</b>	<b>\$ 216,166</b>	<b>\$ 998</b>
<b>Uncollected Payments:</b>				
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	\$ (11,838)	\$ (430)	\$ (11,018)	\$ (536)
Adjustment to Uncollected Payments, Federal Sources	-	-	-	-
Change in Uncollected Customer Payments from Federal Sources	(10,286)	270	(820)	106
<b>Uncollected Payments from Federal Sources, End of Year</b>	<b>\$ (22,124)</b>	<b>\$ (160)</b>	<b>\$ (11,838)</b>	<b>\$ (430)</b>
<b>Memorandum (non-add) Entries:</b>				
Obligated Balance, Start of Year	\$ 204,328	\$ 568	\$ 177,636	\$ 712
Obligated Balance, End of Year	\$ 214,224	\$ 215	\$ 204,328	\$ 568
<b>Budget Authority and Outlays, Net:</b>				
Budget Authority, Gross (Discretionary and Mandatory)	\$ 1,458,538	\$ 130	\$ 1,344,838	\$ 431
Actual Offsetting Collections (Discretionary and Mandatory)	(23,260)	(350)	(23,687)	(315)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	(10,286)	270	(820)	106
<b>Budget Authority, Net (Discretionary and Mandatory)</b>	<b>\$ 1,424,992</b>	<b>\$ 50</b>	<b>\$ 1,320,331</b>	<b>\$ 222</b>
Outlays, Gross (Discretionary and Mandatory)	\$ 1,430,984	\$ 754	\$ 1,320,306	\$ 727
Actual Offsetting Collections (Discretionary and Mandatory)	(23,260)	(350)	(23,687)	(315)
Outlays, Net (Discretionary and Mandatory)	1,407,724	404	1,296,619	412
Distributed Offsetting Receipts	(380,187)	-	(359,650)	-
<b>Agency Outlays, Net (Discretionary and Mandatory)</b>	<b>\$ 1,027,537</b>	<b>\$ 404</b>	<b>\$ 936,969</b>	<b>\$ 412</b>

*The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.*

## U.S. Department of Health and Human Services

## Statement of Social Insurance (unaudited)

75-Year Projection as of January 1, 2015 and Prior Base Years

(in Billions)

	Estimates from Prior Years				
	2015	2014	2013	2012	2011
<i>Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 24 and 25)</i>					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	\$ 9,134	\$ 8,398	\$ 8,147	\$ 7,929	\$ 7,581
SMI Part B	17,027	17,127	15,227	14,431	13,595
SMI Part D	6,424	5,928	5,871	5,866	6,438
Have attained eligibility age (age 65 and over)					
HI	382	332	301	302	262
SMI Part B	3,300	2,873	2,620	2,395	2,122
SMI Part D	887	775	722	694	695
Those expected to become participants					
HI	8,386	7,812	7,744	7,367	7,260
SMI Part B	3,668	4,311	3,530	3,333	3,223
SMI Part D	2,845	2,609	2,617	2,568	2,817
All current and future participants					
HI	17,902	16,542	16,192	15,598	15,104
SMI Part B	23,995	24,311	21,377	20,159	18,940
SMI Part D	10,156	9,312	9,211	9,128	9,950
<i>Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 24 and 25)</i>					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	\$ 14,494	\$ 14,117	\$ 14,629	\$ 14,919	\$ 12,887
SMI Part B	16,818	17,003	15,075	14,303	13,489
SMI Part D	6,424	5,928	5,871	5,866	6,438
Have attained eligibility age (age 65 and over)					
HI	3,803	3,484	3,422	3,369	2,923
SMI Part B	3,637	3,171	2,887	2,646	2,343
SMI Part D	887	775	722	694	695
Those expected to become participants					
HI	2,791	2,764	2,913	2,891	2,546
SMI Part B	3,540	4,137	3,415	3,211	3,108
SMI Part D	2,845	2,609	2,617	2,568	2,817
All current and future participants:					
HI	21,089	20,365	20,963	21,179	18,356
SMI Part B	23,995	24,311	21,377	20,159	18,940
SMI Part D	10,156	9,312	9,211	9,128	9,950
<i>Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)</i>					
HI	\$ (3,187)	\$ (3,823)	\$ (4,772)	\$ (5,581)	\$ (3,252)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
<i>Additional Information</i>					
<i>Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)</i>					
HI	\$ (3,187)	\$ (3,823)	\$ (4,772)	\$ (5,581)	\$ (3,252)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
<i>Trust Fund assets at start of period</i>					
HI	197	205	220	244	272
SMI Part B	68	74	66	80	71
SMI Part D	1	1	1	1	1
<i>Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 24 and 25)</i>					
HI	\$ (2,990)	\$ (3,618)	\$ (4,551)	\$ (5,337)	\$ (2,980)
SMI Part B	68	74	66	80	71
SMI Part D	1	1	1	1	1

Please note for the entirety of the Statement of Social Insurance:

Totals do not necessarily equal the sum of the rounded components.

Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

**U.S. Department of Health and Human Services**  
**Statement of Social Insurance (Continued) (unaudited)**  
 75-Year Projection as of January 1, 2015 and Prior Base Years  
 (in Billions)

	Estimates from Prior Years				
	2015	2014	2013	2012	2011
<b>Medicare Social Insurance Summary</b>					
<b>Current Participants:</b>					
<i>Actuarial present value for the 75-year projection period from or on behalf of:</i>					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	\$ 4,569	\$ 3,980	\$ 3,643	\$ 3,391	\$ 3,079
Expenditures	8,328	7,430	7,031	6,709	5,961
Income less expenditures	(3,759)	(3,450)	(3,388)	(3,319)	(2,882)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	32,585	31,453	29,244	28,227	27,615
Expenditures	37,736	37,048	35,574	35,088	32,814
Income less expenditures	(5,151)	(5,595)	(6,330)	(6,861)	(5,199)
<i>Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)</i>	(8,909)	(9,045)	(9,718)	(10,180)	(8,081)
<i>Combined Medicare Trust Fund assets at start of period</i>	266	280	288	325	344
<i>Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period</i>	(8,643)	(8,764)	(9,430)	(9,855)	(7,737)
<b>Future Participants:</b>					
<i>Actuarial present value for the 75-year projection period:</i>					
Income (excluding interest)	14,898	14,732	13,891	13,268	13,300
Expenditures	9,176	9,510	8,945	8,669	8,471
Income less expenditures	5,722	5,222	4,946	4,599	4,829
<b>Open-Group (all current and future participants):</b>					
<i>Actuarial present value of estimated future income (excluding interest) less expenditures</i>	(3,187)	(3,823)	(4,772)	(5,581)	(3,252)
<i>Combined Medicare Trust Fund assets at start of period</i>	266	280	288	325	344
<i>Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period</i>	\$ (2,921)	\$ (3,542)	\$ (4,484)	\$ (5,256)	\$ (2,908)

*Please note for the entirety of the Statement of Social Insurance:*

*Totals do not necessarily equal the sum of the rounded components.*

*Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.*

*The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.*

**U.S. Department of Health and Human Services**  
**Statement of Changes in Social Insurance Amounts (unaudited)**  
January 1, 2014 to January 1, 2015  
Medicare Hospital and Supplementary Medical Insurance  
(in Billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
<b><i>Total Medicare (Note 26)</i></b>					
As of January 1, 2014	\$ 50,166	\$ 53,988	\$ (3,823)	\$ 280	\$ (3,542)
Reasons for change					
Change in the valuation period	2,106	2,308	(202)	(17)	(219)
Change in projection base	1,174	1,256	(82)	3	(79)
Changes in the demographic assumptions	149	184	(35)	-	(35)
Changes in economic and health care assumptions	(1,884)	(2,638)	755	-	755
Changes in law	342	142	201	-	201
Net changes	1,887	1,251	636	(14)	622
As of January 1, 2015	\$ 52,053	\$ 55,240	\$ (3,187)	\$ 266	\$ (2,921)
<b><i>HI - Part A (Note 26)</i></b>					
As of January 1, 2014	\$ 16,542	\$ 20,365	\$ (3,823)	\$ 205	\$ (3,618)
Reasons for change					
Change in the valuation period	610	812	(202)	(14)	(216)
Change in projection base	(38)	44	(82)	6	(77)
Changes in the demographic assumptions	3	38	(35)	-	(35)
Changes in economic and health care assumptions	784	30	755	-	755
Changes in law	-	(201)	201	-	201
Net changes	1,360	724	636	(8)	628
As of January 1, 2015	\$ 17,902	\$ 21,089	\$ (3,187)	\$ 197	\$ (2,990)
<b><i>SMI - Part B (Note 26)</i></b>					
As of January 1, 2014	\$ 24,311	\$ 24,311	\$ -	\$ 74	\$ 74
Reasons for change					
Change in the valuation period	1,054	1,054	-	(3)	(3)
Change in projection base	360	360	-	(3)	(3)
Changes in the demographic assumptions	82	82	-	-	-
Changes in economic and health care assumptions	(2,168)	(2,168)	-	-	-
Changes in law	356	356	-	-	-
Net changes	(316)	(316)	-	(6)	(6)
As of January 1, 2015	\$ 23,995	\$ 23,995	\$ -	\$ 68	\$ 68
<b><i>SMI - Part D (Note 26)</i></b>					
As of January 1, 2014	\$ 9,312	\$ 9,312	\$ -	\$ 1	\$ 1
Reasons for change					
Change in the valuation period	443	443	-	-	-
Change in projection base	852	852	-	-	-
Changes in the demographic assumptions	63	63	-	-	-
Changes in economic and health care assumptions	(500)	(500)	-	-	-
Changes in law	(13)	(13)	-	-	-
Net changes	844	844	-	-	-
As of January 1, 2015	\$ 10,156	\$ 10,156	\$ -	\$ 1	\$ 1

*Totals do not necessarily equal the sum of the rounded components.*

*The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.*

**U.S. Department of Health and Human Services**  
**Statement of Changes in Social Insurance Amounts (unaudited)**  
January 1, 2013 to January 1, 2014  
Medicare Hospital and Supplementary Medical Insurance  
(in Billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
<b><i>Total Medicare (Note 26)</i></b>					
As of January 1, 2013	\$ 46,779	\$ 51,550	\$ (4,772)	\$ 288	\$ (4,484)
Reasons for change					
Change in the valuation period	1,962	2,201	(239)	(19)	(258)
Change in projection base	(98)	(545)	447	12	458
Changes in the demographic assumptions	180	318	(139)	-	(139)
Changes in economic and health care assumptions	1,293	521	772	-	772
Changes in law	50	(57)	108	-	108
Net changes	3,387	2,438	949	(7)	942
As of January 1, 2014	\$ 50,166	\$ 53,988	\$ (3,823)	\$ 280	\$ (3,542)
<b><i>HI - Part A (Note 26)</i></b>					
As of January 1, 2013	\$ 16,192	\$ 20,963	\$ (4,772)	\$ 220	\$ (4,551)
Reasons for change					
Change in the valuation period	619	858	(239)	(22)	(261)
Change in projection base	123	(323)	447	7	454
Changes in the demographic assumptions	(45)	93	(139)	-	(139)
Changes in economic and health care assumptions	(346)	(1,118)	772	-	772
Changes in law	-	(108)	108	-	108
Net changes	350	(598)	949	(15)	934
As of January 1, 2014	\$ 16,542	\$ 20,365	\$ (3,823)	\$ 205	\$ (3,618)
<b><i>SMI - Part B (Note 26)</i></b>					
As of January 1, 2013	\$ 21,377	\$ 21,377	\$ -	\$ 66	\$ 66
Reasons for change					
Change in the valuation period	894	894	-	3	3
Change in projection base	(391)	(391)	-	4	4
Changes in the demographic assumptions	(203)	(203)	-	-	-
Changes in economic and health care assumptions	2,638	2,638	-	-	-
Changes in law	(2)	(2)	-	-	-
Net changes	2,935	2,935	-	8	8
As of January 1, 2014	\$ 24,311	\$ 24,311	\$ -	\$ 74	\$ 74
<b><i>SMI - Part D (Note 26)</i></b>					
As of January 1, 2013	\$ 9,211	\$ 9,211	\$ -	\$ 1	\$ 1
Reasons for change					
Change in the valuation period	450	450	-	-	-
Change in projection base	170	170	-	-	-
Changes in the demographic assumptions	428	428	-	-	-
Changes in economic and health care assumptions	(999)	(999)	-	-	-
Changes in law	53	53	-	-	-
Net changes	102	102	-	-	-
As of January 1, 2014	\$ 9,312	\$ 9,312	\$ -	\$ 1	\$ 1

*Totals do not necessarily equal the sum of the rounded components.*

*The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.*

## NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

### Note 1. Summary of Significant Accounting Policies

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#### A. Reporting Entity

The accompanying financial statements include activities and operations of the United States Department of Health and Human Services (HHS or the Department).

HHS is a Cabinet-level agency of the executive branch of the federal government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the *Department of Education Organization Act* was signed into law, creating a separate Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

#### *Organization and Structure of HHS*

HHS is composed of the Office of the Secretary (OS) and 11 Operating Divisions (OpDivs) with diverse missions and programs. OS and the OpDivs are each responsible for carrying out a mission, conducting a major line of activity or producing one or a group of related products and/or services. Although organizationally located within OS, the Program Support Center is a responsibility segment and reports separately because its business activities encompass offering services to other federal agencies and HHS OpDivs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) for financial reporting purposes. Therefore, references to the CDC responsibility segment include ATSDR. Managers of the responsibility segments report directly to the Department's top management and the resources and results of operations can be clearly distinguished from those of other responsibility segments. The 12 responsibility segments are:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of the Secretary (OS) – excluding the Program Support Center
- Program Support Center (PSC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

HHS partners with other agencies to accomplish its mission. One such partnership is with the Department of Homeland Security (DHS) for the Biodefense Countermeasures Fund. It is reported on HHS financial statements under the OS responsibility segment.

Pursuant to Public Law 113-128, Section 491 of the *Workforce Innovation and Opportunity Act* (WIOA), ACL received three groups of programs from the Department of Education, Office of Special Education and Rehabilitation Services. These programs are the National Institute on Disability, Independent Living and



Rehabilitation Research programs; the Independent Living programs; and the Assistive Technology programs. The transfer was effective March 30, 2015. Through the transfer of these programs, HHS received the appropriations that fund the programs and has full administration, monitoring and reporting responsibilities of the program objectives.

## **B. Basis of Accounting and Presentation**

HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S. Code (U.S.C.) §3515(b), the *Chief Financial Officer Act of 1990*, as amended by the *Government Management Reform Act of 1994* (GMRA), and are presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements* (OMB Circular A-136). These statements have been prepared from HHS's financial records in conformity with accounting principles generally accepted in the United States (U.S.). The generally accepted accounting principles (GAAP) for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants (AICPA) as federal GAAP.

Transactions are recorded on an accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when resources are consumed, without regard to the payment of cash. Budgetary accounting principles are designed to recognize budgetary resources that have been provided to an agency through various means, such as appropriations, reimbursable activity, or fee-based services, and the status of those funds throughout the consumption cycle. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of federal funds.

The financial statements consolidate the balances of approximately 250 appropriations and related fund accounts. The fund accounts include accounts used for suspense, collection of receipts, and general government functions. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheets and Statements of Net Cost and Changes in Net Position. The Combined Statement of Budgetary Resources is presented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from these statements. Supplemental information is accumulated from the OpDivs' reports, regulatory reports and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. government, a sovereign entity. One implication of this is that liabilities cannot be created or liquidated without legislation providing budgetary authority and resources for HHS.

## **C. Use of Estimates in Preparing Financial Statements**

Financial statements prepared in accordance with accounting principles generally accepted in the United States are based on the selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist the reader in understanding the effect of changes in assumptions on the related information.

## **D. Parent/Child Reporting**

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. HHS is party to allocation transfers with other federal entities as both a transferring (parent) entity and a receiving (child) entity. All financial activity related to these allocation transfers is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations, and budget apportionments are derived.

HHS received an exception to the parent/child reporting requirements of OMB Circular A-136, as it pertains to the allocation transfer from DHS to HHS for the Biodefense Countermeasures Fund for FY 2008 and beyond. Under this exception, HHS, as the child, assumed the financial statement reporting responsibilities of this fund.

Under the *Affordable Care Act*, HHS has established a child relationship with the Internal Revenue Service (IRS) of the Department of the Treasury (Treasury) for the payment of the advance premium tax credits and cost-sharing reductions to insurance providers. No financial activity is included in HHS's financial statements.

HHS also receives allocation transfers, as the child, from the Departments of Agriculture, Justice, and State. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of Interior (DOI), Treasury, and Social Security Administration (SSA).

### **E. Reclassifications and Adjustments**

Certain FY 2014 balances have been reclassified to conform to FY 2015 financial statement presentations. The effects are immaterial.

### **F. Funds from Dedicated Collections**

Generally, funds from dedicated collections are financed by specifically identified revenues, provided to the government by non-federal sources, often supplemented by other financing sources, which remain available over time. Dedicated collections must meet the following criteria:

1. A statute committing the federal government to use specifically identified revenues and/or other financing sources that are originally provided to the federal government from a non-federal source only for designated activities, benefits or purposes;
2. Explicit authority for the fund to retain revenues and/or other financing sources not used in the current period for future use to finance the designated activities, benefits or purposes; and
3. A requirement to account for and report on the receipt, use, and retention of the revenues and/or other financing sources that distinguishes the dedicated collections from the federal government's general revenues.

HHS's major funds from dedicated collections are described in the sections following.

#### ***Medicare Hospital Insurance (HI) Trust Fund – Part A***

Section 1817 of the *Social Security Act of 1935* (*Social Security Act*) established the Medicare HI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for hospital in-patient services, hospice and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. A portion of HHS payments to Medicare Advantage Plans (previously known as Managed Care Plans) is also charged to this fund. The financial statements include the HI Trust Fund activities administered by the Treasury. The HI Trust Fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for the Medicare HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contributions Act* (FICA) (26 U.S.C. Ch 21) and *Self Employment Contributions Act of 1954* (SECA) (Ch 2 of Subtitle A of the Internal Revenue Code, 26 U.S.C. §1401 through §1403). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contribute the full 2.9 percent of their self-employment income. The *Social Security Act* requires the transfer of these contributions from the Treasury General Fund to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security

from the SSA records of wages. The SSA uses the wage totals reported by employers to the IRS via the Employer's Quarterly Federal Tax Return, as the basis for its quarterly certification of regular wages.

***Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B***

Section 1841 of the *Social Security Act* established the Medicare SMI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for physicians, medical suppliers, laboratory services, hospital outpatient services and rehabilitation, ambulatory surgical centers, end stage renal disease treatment, rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. A portion of HHS payments to Medicare Advantage Plans is also charged to this fund. The financial statements include SMI Trust Fund activities administered by Treasury. The SMI Trust Fund has permanent indefinite authority.

SMI benefits and administrative expenses are financed primarily by monthly premiums paid by Medicare beneficiaries with matching by the federal government through the General Fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected and outlines the ratio for the match as well as the method to fully compensate the Trust Fund if insufficient funds are available in the appropriation to match all premiums received in the FY.

***Medicare SMI Trust Fund – Part D***

The *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (*Medicare Modernization Act* or MMA) established the Medicare Prescription Drug Benefit – Part D. The program makes a prescription drug benefit available to all Medicare beneficiaries who opt into the program. Beneficiaries eligible for Medicaid are automatically enrolled unless they have other credible drug coverage. HHS reports the Prescription Drug Benefit within the financial statements as part of the SMI Trust Fund, in the Medicare column. Drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans, which add coverage to fee-for-service Medicare; and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. Medicare helps employers and unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy. The Low Income Subsidy helps those with limited income and resources.

***Medicare Integrity Program***

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program and codified the Medicare Integrity Program activities previously known as "payment safeguards." The HIPAA also established the Health Care Fraud and Abuse Control Account, which includes a dedicated appropriation for carrying out the Medicare Integrity Program. Through the Medicare Integrity Program, HHS contracts with eligible entities to perform medical and utilization reviews, fraud reviews, and cost report audits. In addition, the Department educates providers and beneficiaries, about payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI Trust Fund.

**G. Revenue and Financing Sources**

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriation and user fees. The United States Constitution prescribes that no money may be expended by an agency unless the funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by HHS. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

**Appropriations**

HHS receives annual, multi-year, and no-year appropriations that may be used within statutory limits. For example, funds for general operations are normally made available for one FY, funds for long-term projects, such as major construction, will be available for the expected life of the project and funds used to establish revolving fund operations are generally available indefinitely (i.e., no-year funds).

**Permanent Indefinite Appropriations**

HHS permanent indefinite appropriations are open-ended and the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

**Borrowing Authority**

HHS uses indefinite borrowing authority under the *Federal Credit Reform Act*, as amended, for its loan programs. Borrowing authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. Any unobligated borrowing authority does not carry forward to the next FY. HHS has two programs with borrowing authority: the CMS Consumer Operated and Oriented Plan (CO-OP) Loan Program and the Health Center Loan Program.

HHS reports loans in accordance with the *Federal Credit Reform Act*. Budgetary related activity is reported separately within the Combined Statement of Budgetary Resources.

**Exchange Revenue**

Exchange revenue results when HHS provides goods or services to another entity for a price and is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

HHS pricing policy for reimbursable agreements is to recover full cost and should result in no profit or loss for HHS. In addition to revenues related to reimbursable agreements, HHS collects various user fees to offset the cost of its programs. Certain fees charged by HHS are based on an amount set by law or regulation and may not represent full cost.

With minor exceptions, all revenue receipts by federal agencies are processed through the Treasury Central Accounting Reporting System. Regardless of whether they are derived from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate HHS use are deposited in the General or Special Funds of the Treasury. Amounts not retained for use by HHS are reported as Transfers-in/out Without Reimbursement to other government agencies on HHS Consolidated Statement of Changes in Net Position.

**Non-Exchange Revenue**

Non-exchange revenue results from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally-enforceable claim to resources arises, but only to the extent that collection is probable and the amount is reasonably estimable.

Non-exchange revenue is not considered to reduce the cost of the Department's operations and is separately reported on the Consolidated Statement of Changes in Net Position. Employment tax revenue collected under FICA and SECA is considered non-exchange revenue.

***Imputed Financing Sources***

In certain instances, HHS's operating costs are paid out of funds appropriated to other federal entities. For example, by law certain costs of retirement programs are paid by the Office of Personnel Management and certain legal judgments against HHS are paid from the Judgment Fund maintained by Treasury. When costs are identifiable to HHS and directly attributable to HHS's operations and are paid by other agencies, HHS recognizes these amounts as imputed costs within the Consolidated Statement of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

**H. Intragovernmental Transactions and Relationships**

Intragovernmental transactions are business activities conducted between two different federal entities. Transactions with the public are transactions in which either the buyer or seller of the goods or services is a non-federal entity.

If a federal entity purchases goods or services from another federal entity and sells them to the public, the exchange revenue is classified as with the public, but the related costs would be classified as intragovernmental. The purpose of the classifications is to enable the federal government to provide consolidated financial statements and not to match public and intragovernmental revenue with costs incurred to produce public and intragovernmental revenue.

In the course of operations, HHS has relationships and financial transactions with numerous federal agencies including SSA and Treasury. The SSA determines eligibility for Medicare programs and also deducts Medicare Part B premiums from Social Security benefit payments for Social Security beneficiaries who elect to enroll in the Medicare Part B program and elect to deduct their premiums from their benefit checks. SSA then transfers those funds to the Medicare SMI Trust Fund. The Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Medicare Part D is primarily financed by the General Fund of the Treasury, as well as beneficiary premiums and payments from states.

**I. Entity and Non-Entity Assets**

Entity assets are assets the reporting entity has authority to use in its operations (i.e., management has the authority to decide how the funds are used), or management is legally obligated to use the funds to meet the entity obligations.

Non-entity assets are assets held by the reporting entity, but not available for use. HHS non-entity assets are composed of delinquent child support payments for the Child Support Enforcement Program, which are withheld from federal tax refunds and interest accrued on over-payments and cost settlements reported by the Medicare contractors.

**J. Fund Balance with Treasury (FBwT)**

HHS maintains its available funds with Treasury. The FBwT is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by the Treasury. HHS FBwT accounts are reconciled with those of Treasury on a regular basis.

**K. Custodial Activity**

In accordance with guidance set forth in OMB Circular A-136, HHS reports custodial activities on its Consolidated Balance Sheets. The majority of the custodial collections are received by ACF from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. Since custodial activities are immaterial to HHS and incidental to its operations, HHS does not prepare a separate

Statement of Custodial Activity; the amount of custodial collections and dispositions in the current FY is reported in Note 21.

#### **L. Investments, Net**

HHS invests entity Medicare Trust Fund balances in excess of current needs in U.S. securities. The Treasury acts as the fiscal agent for the federal government's investments in securities. Sections 1817 and 1841 of the *Social Security Act* require that Trust Funds not necessary to meet current expenditures be invested in interest-bearing obligations or in obligations guaranteed as to both principal and interest by the federal government. The cash receipts, collected from the public as dedicated collections, are deposited with Treasury, which uses the cash for general governmental purposes. Treasury securities are issued by the Bureau of the Fiscal Service to the HI and SMI Trust Funds as evidence of their receipt and are reported as an asset for the Trust Funds and a corresponding liability of the Treasury. The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI Trust Funds.

The Treasury securities provide the HI and SMI Trust Funds with authority to draw upon Treasury to make future benefit payments or other expenditures. When the Trust Funds require redemption of these securities to make expenditures, the government finances the expenditures by raising taxes, raising other receipts, borrowing from the public or repaying less debt, or curtailing other expenditures. This is the same way that the government finances all expenditures.

The Treasury securities issued and redeemed to the HI and SMI Trust Funds are Non-Marketable (Par Value) securities. These investments are carried at face value as determined by Treasury. Interest income is compounded semi-annually (June and December) by Treasury and at FY-end is adjusted to include an accrual for interest earned from July 1 to September 30 (See Note 4).

The Vaccine Injury Compensation Trust Fund, a dedicated collections fund similar to the HI and SMI Trust Funds, invests in Non-Marketable, Market-Based securities issued by the Bureau of the Fiscal Service in the form of One Day Certificates and Market-Based Bills, Notes and Bonds.

The NIH Gift Funds are invested in Non-Marketable, Market-Based Securities issued by the Bureau of the Fiscal Service. Funds are invested for either a 90 or 180-day period based on the need for funds. No provision is made for unrealized gains or losses on these securities since it is HHS's intent to hold investments to maturity.

The *Children's Health Insurance Program Reauthorization Act* (CHIPRA) established the Child Enrollment Contingency Fund to provide additional funding to states that experience shortfalls in their CHIP. The *Affordable Care Act* extended the availability of the fund through 2015, and the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) extended the availability of the fund through 2017. This fund is invested in Non-Marketable, Market-Based Bills issued by the Bureau of the Fiscal Service. These investments will be redeemed as funds are needed by the states to cover short-term shortfalls in the program.

#### **M. Accounts Receivable, Net**

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible amounts on public receivables. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for reimbursable work. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible. Accounts Receivable, Net from the public is primarily composed of provider and beneficiary over-payments, Medicare Prescription Drug over-payments, Medicare premiums, civil monetary penalties (CMP) & Other Restitutions, state phased-down contributions, Medicaid/CHIP

overpayments, audit disallowances, and the recognition of Medicare Secondary Payer (MSP) accounts receivable, and monies due for Affordable Insurance Marketplaces (Marketplace) activities.

Accounts Receivable, Net from the public is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, HHS calculates the allowance for uncollectible amounts based on the collection activity and the age of the debt for the most current FY, while taking into consideration the average uncollectible percentage for the preceding five years. The Medicaid accounts receivable have been recorded at a net realizable amount based on historical analyses of actual recoveries and the rate of disallowances found in favor of the states.

## **N. Advances and Accrued Liabilities**

HHS awards grants to various grantees and provides advance payments to meet grantees' cash needs to carry out HHS programs. Advance payments are liquidated upon grantees reporting expenditures on the quarterly *Federal Financial Report*. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the Advances account to a negative balance. An Accrued Grant Liability occurs when the accrued grant expenses exceed the outstanding advances to grantees.

HHS grants are classified into two categories: "Grants Not Subject to Grant Expense Accrual" and "Grants Subject to Grant Expense Accrual." "Grants Not Subject to Grant Expense Accrual" represents formula grants (also referred to as "block grants"). Expenses are recorded on the cash-basis of accounting, as the grantees draw funds. For "Grants Subject to Grant Expense Accrual," commonly referred to as "non-block grants," grantees draw funds based on their estimated cash needs. As grantees report their actual disbursements quarterly, the amounts are recorded as expenses and their advance balances are reduced. At year-end, the OpDivs report both actual payments made through the fourth quarter and an unreported grant expenditure estimate (accrual) based on historical spending patterns of the grantees.

As of September 30, 2015, other accrued liabilities include expenses accrued for the risk adjustment and reinsurance programs that are administered by CMS under the *Affordable Care Act* (see Note 1.Y). These amounts represent estimates of payments due to those participating in the Marketplace activities. Related contributions due from other health insurers in the Marketplace are reported in Accounts Receivable.

## **O. Inventory and Related Property, Net**

Inventory and Related Property, Net primarily consists of Inventory Held for Sale, Operating Materials and Supplies, and Stockpile Materials.

Inventory Held for Sale consists of small equipment and supplies held by the Service and Supply Funds (SSF) for sale to HHS components and other federal entities. Inventories Held for Sale are valued at historical cost using the weighted average valuation method for the PSC SSF's inventories and using the moving average valuation method for the NIH SSF's inventories.

Operating Materials and Supplies include pharmaceuticals, biological products, and other medical supplies used to provide medical services and conduct medical research. They are recorded as assets when purchased and are expensed when consumed. Operating Materials and Supplies are valued at historical cost using the first-in/first-out (FIFO) cost flow assumption.

Stockpile Materials are held in reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Vaccines for Children (VFC) and Avian Influenza (H5N1). The H5N1 vaccine stockpile is held in reserve to respond to an avian



pandemic declaration. The stockpile contains several million doses of vaccine in bulk, which is stored and maintained for possible use.

Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulin antitoxins, and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC and H5N1.

## **P. General Property, Plant and Equipment, Net**

The General Property, Plant and Equipment (PP&E), Net consists of buildings, structures, and facilities used for general operations, land acquired for general operating purposes, equipment; assets under capital lease, leasehold improvements, construction-in-progress; and internal use software. The basis for recording purchased PP&E is full cost, including all costs incurred to bring the PP&E to a form and location suitable for its intended use, and is presented net of accumulated depreciation.

The cost of PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. When property is acquired through a donation, the cost recognized is the estimated fair market value on the date of acquisition. The cost of PP&E transferred from other federal entities is the transferring entity's net book value. Except for internal use software, HHS capitalizes all PP&E with an initial acquisition cost of \$25,000 or more and an estimated useful life of two years or more.

HHS has commitments under various operating leases with private entities and General Services Administration (GSA) for offices, laboratory space, and land. Leases with private entities have initial or remaining non-cancelable lease terms from 1 to 50 years. The GSA leases, in general, are cancelable with 120 days notice. Under an operating lease, the cost of the lease is expensed as incurred.

PP&E is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

In accordance with Statement of Federal Financial Accounting Standard (SFFAS) Number 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS's capitalization threshold for internal use software costs for appropriated fund accounts is \$1.0 million and the threshold for revolving fund accounts is \$500 thousand. Costs below the threshold levels are expensed. Software is amortized using the straight line method over a period of 7 to 10 years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

## **Q. Stewardship Land**

HHS stewardship land (land not acquired for or in connection with general PP&E) is Indian Trust land used to support the IHS day-to-day operations of providing health care to American Indians and Alaska Natives in remote areas of the country where no other facilities exist. In accordance with SFFAS Number 29, *Heritage Assets and Stewardship Land*, HHS does not report a related amount on the Consolidated Balance Sheets.

The Indian Trust lands used by IHS are held as separate and distinct reflecting the long-term trust responsibility. IHS has built health care facilities on these Trust lands. Trust lands, when no longer needed by the IHS in connection with its general use PP&E, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight.



HHS asset accountability reports differentiate Indian Trust land parcels from General PP&E situated thereon. Note 20 provides additional information on HHS's Stewardship Land.

## R. Liabilities

Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare HI Trust Fund, since liabilities are only those items that are present obligations of the government. HHS's liabilities are classified as covered by budgetary resources or not covered by budgetary resources.

### *Liabilities Covered by Budgetary Resources*

Available budgetary resources include new budget authority, spending authority from offsetting collections, recoveries of expired budget authority, unobligated balances of budgetary resources at the beginning of the year, permanent indefinite appropriation, and borrowing authority.

### *Liabilities Not Covered by Budgetary Resources*

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include contingencies, employee annual leave earned, but not taken, and amounts billed by the Department of Labor (DOL) for the *Federal Employees' Compensation Act of 1916* (FECA) (5 U.S.C. 751) disability payments. The actuarial FECA liability determined by the DOL but not yet billed is also included in this category.

## S. Accounts Payable

Accounts Payable primarily consists of amounts due for goods and services received progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

## T. Accrued Payroll and Benefits

Accrued Payroll and Benefits consists of salaries, wages, leave, and benefits earned by employees but not disbursed at the end of the reporting period. A liability for annual and other vested compensatory leave is accrued as earned and reduced when taken. At the end of each FY, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability since it will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consists primarily of HHS's current FECA liability to DOL.

## U. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare, Medicaid and CHIP owed to the public for medical services Incurred But Not Reported (IBNR) as of the end of the reporting period. The Medicare and Medicaid programs are the largest entitlement programs in HHS.

### *Medicare*

The Medicare liability is developed by the CMS Office of the Actuary and includes:

- An estimate of claims incurred that may or may not have been submitted to the Medicare contractors, but not yet approved for payment;

- Actual claims approved for payment by the Medicare contractors for which checks have not yet been issued;
- Checks issued by the Medicare contractors in payment of claims that have not yet been cashed by payees;
- Periodic interim payments for services rendered in the current FY but paid in the subsequent FY;
- An estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

HHS develops estimates for medical costs IBNR using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, medical care professional contract rate changes, medical care consumption, and other medical cost trends. HHS estimates liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, HHS re-examines previously established medical cost payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, HHS adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, HHS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

#### ***Medicaid and CHIP***

The Medicaid and CHIP estimates represent the net federal share of expenses incurred by the states but not yet reported to HHS. This estimate is developed based on historical relationships between prior net payables to the states and current activity.

### **V. Federal Employee and Veterans' Benefits**

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory benefit plan, for its active duty officers, retiree annuitants and survivors. The plan does not have accumulated assets and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. HHS records the present value of the Commissioned Corps pension and post-retirement health benefits.

The liability for federal employee and veterans' benefits also includes an actuarial liability for estimated future payments for workers' compensation pursuant to the FECA. The FECA provides income and medical cost protection to federal employees injured on the job or who sustained a work-related occupational disease. It also covers beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by the DOL which pays valid claims and subsequently bills the employing federal agency. The FECA liability consists of two components: (1) actual claims billed by the DOL to agencies but not yet paid; and (2) an estimated liability for future benefit payments as a result of past events such as death, disability, and medical costs. The claims that have been billed by DOL are included in Accrued Payroll and Benefits.

Most HHS employees participate in the Civil Service Retirement System (CSRS), a defined benefit plan, or the Federal Employees' Retirement System (FERS), a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. The FERS plan has three parts: a defined benefit payment, Social Security benefits, and the Thrift Savings Plan. For employees covered under FERS, HHS contributes a fixed percentage of pay for the defined benefit portion and the employer's matching share for Social Security and Medicare Insurance. HHS automatically contributes 1 percent of each employee's pay to the Thrift Savings Plan

and matches the first 3 percent of employee contributions dollar for dollar. Each additional dollar of the employee's next 2 percent of basic pay is matched at 50 cents on the dollar.

The Office of Personnel Management is the administering agency for both of these benefit plans and, thus, reports CSRS and FERS assets, accumulated plan benefits and unfunded liabilities applicable to federal employees. Therefore, HHS does not recognize any liability on its Consolidated Balance Sheets for pensions, other retirement benefits, and other post-employment benefits of its federal employees with the exception of the PHS Commissioned Corps. HHS does, however, recognize an expense in the Consolidated Statement of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

## W. Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to HHS. The uncertainty ultimately should be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS Number 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS Number 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities.

HHS and its components could be parties to various administrative proceedings, legal actions, and claims brought by or against it. With the exception of pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur and the related future outflow or sacrifice of resources is measurable. For pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur and the related future outflow or sacrifice of resources is measurable.

HHS has no material obligations related to cancelled appropriations for which we have a contractual commitment for payment or for contractual arrangements, which many require future financial obligations.

## X. Statement of Social Insurance

The Statement of Social Insurance presents the projected 75-year actuarial present values of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-specific conditions. The projected potential future income and expenditures under current law are not included in the accompanying Consolidated Balance Sheets, Statements of Net Cost and Changes in Net Position or Combined Statement of Budgetary Resources.

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. The basis for projections in this report has changed since last year due to the enactment of MACRA. This law terminated the sustainable growth rate (SGR) formula that both set physician fee schedule payments and required payment reductions that were overridden by Congress for every year from 2002 through 2015. The projections in this report (with one exception related to depletion of the HI Trust Fund), are based on current law; that is, they assume that laws on the books will be implemented and adhered to with

respect to scheduled taxes, premium revenues, and payments to providers and health plans. The estimates depend on many economic, demographic, and health care-specific assumptions. These include changes in per beneficiary health care cost, wages, the gross domestic product (GDP), the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The assumptions underlying the Statement of Social Insurance actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2015*. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

### **Y. Affordable Care Act**

In FY 2010, President Barack Obama signed health insurance reform legislation giving Americans more control over their health care. The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* collectively referred to as the *Affordable Care Act* ensures that all Americans have access to quality, affordable health care, while helping to reduce health care costs. Further information is available at [www.HealthCare.gov](http://www.HealthCare.gov).

The *Affordable Care Act* contains the most significant changes to health care coverage since the passing of the *Social Security Act*. The *Affordable Care Act* provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). The programs under CCIIO include the Marketplace and other programs listed below. A brief description of these programs and their impact on the financial statement is presented below.

#### ***Affordable Insurance Marketplaces***

Grants have been provided to the states to establish Affordable Insurance Marketplaces. The initial grants were made by the HHS to the states “not later than one (1) year after the date of enactment.” Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS. All Marketplaces were launched on October 1, 2013.

To help make health insurance more affordable to consumers, HHS makes advance payments of the premium tax credits (APTC) and cost-sharing reductions (CSR) to health insurance issuers on behalf of consumers who are eligible for financial assistance. APTC and CSR payments (which are included in the IRS financial statements) are a critical component of the Marketplace, and \$30.0 billion has been allocated for these payments. In addition to these payments on behalf of consumers, HHS collects Marketplace user fees from issuers participating in the Federally-facilitated Marketplace (FFM).

#### ***Basic Health Program***

The Basic Health Program (BHP) gives states the ability to provide more affordable coverage for low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and CHIP levels. Through the BHP, states can provide coverage to individuals who do not qualify for Medicaid, CHIP, or other minimum essential coverage and have income between 133 percent and 200 percent of the federal poverty level (FPL). A state that operates a BHP will receive federal funding equal to 95 percent of the amount of the premium tax credits and the cost sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in Qualified Health Plans through the Marketplace. Similar to APTC and CSR payments, BHP payment amounts are included in the IRS financial statements.

**Consumer Operated and Oriented Plan Program**

The CO-OP Program fosters qualified non-profit health insurance issuers created to offer qualified health plans to the individual and small group markets. Under this program, HHS provides assistance to organizations applying to become qualified non-profit health insurance issuers through loans to assist in meeting start-up costs and to assist the applicant meet state solvency requirements. In accordance with regulations as well as legislative requirements, start-up loans shall be repaid within five years and the solvency loans within 15 years after disbursement, considering state reserve requirements and solvency regulations.

**Transitional Reinsurance Program**

The Transitional Reinsurance program was established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016. All health insurance issuers and third party administrators, on behalf of some self-insured group health plans, must make contributions to support reinsurance payments that cover high-cost individuals in non-grandfathered plans in the individual market, inside and outside the Marketplace. The Transitional Reinsurance program is a critical element in helping to ensure a stabilized individual market in the first years of the Exchange operation of the Marketplace.

**Risk Adjustment Program**

The Risk Adjustment program is a permanent program. It applies to non-grandfathered individual market and small group market plans inside and outside the Marketplaces. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against risk selection and adverse selection. States may operate risk adjustment programs and CMS will operate a risk adjustment program for each state that does not operate its own. In 2014 and 2015, Massachusetts is the only state that operated its own risk adjustment program.

**Risk Corridor Program**

The temporary Risk Corridors program will operate during the years 2014 through 2016. This program applies to qualified health plans in the individual and small group markets, inside and outside the Marketplaces and protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between CMS and qualified health plans to help ensure stable health insurance premiums.

**Note 2. Entity and Non-Entity Assets (in Millions)**

	2015	2014
Non-Entity Intragovernmental Assets		
Fund Balance with Treasury	\$ 8	\$ 8
Accounts Receivable	3	-
Total Non-Entity Intragovernmental Assets	11	8
Accounts Receivable With the Public	27	20
Total Non-Entity Assets	38	28
Total Entity Assets	528,757	482,287
Total Assets	\$ 528,795	\$ 482,315

**Note 3. Fund Balance with Treasury (in Millions)**

	2015	2014
Fund Balance with Treasury		
Trust Funds	\$ 45,056	\$ 19,551
Revolving Funds	1,433	1,275
Appropriated Funds	170,155	155,736
Special Funds and Other Funds	2,815	396
<b>Total</b>	<b>\$ 219,459</b>	<b>\$ 176,958</b>
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	\$ 23,828	\$ 29,423
Unavailable	41,796	8,458
Obligated Balance not yet Disbursed	214,439	204,896
Non-Budgetary Fund Balance with Treasury	(60,604)	(65,819)
<b>Total</b>	<b>\$ 219,459</b>	<b>\$ 176,958</b>

The FBwT are funds primarily available to pay current expenditures and liabilities. Special Funds include the *Affordable Care Act* Risk Programs of \$2.2 billion and Other Funds include balances in deposit, Management Funds, and related non-spending accounts. The Unobligated Balance Available includes funds that are restricted for future use and not apportioned for current use of \$14.5 billion and \$12.4 billion as of September 30, 2015 and September 30, 2014, respectively. The restricted amount is primarily for the *Affordable Care Act* programs, CHIP, CMS Program Management, and State Grants and Demonstrations.

**Note 4. Investments, Net (in Millions)**

<u>2015</u>	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	\$ 261,585	\$ -	\$ 2,408	\$ 263,993	\$ 263,993
Non-Marketable: Market-Based	5,825	(194)	27	5,658	5,658
<b>Total, Intragovernmental</b>	<b>\$ 267,410</b>	<b>\$ (194)</b>	<b>\$ 2,435</b>	<b>\$ 269,651</b>	<b>\$ 269,651</b>

<u>2014</u>	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	\$ 270,598	\$ -	\$ 2,688	\$ 273,286	\$ 273,286
Non-Marketable: Market-Based	5,779	(193)	28	5,614	5,614
<b>Total, Intragovernmental</b>	<b>\$ 276,377</b>	<b>\$ (193)</b>	<b>\$ 2,716</b>	<b>\$ 278,900</b>	<b>\$ 278,900</b>

HHS investments consist primarily of Medicare Trust Fund (funds from dedicated collections) investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2016 through June 30, 2029, with interest rates ranging from 2.0 percent to 5.625 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2016, with an interest rate of 2.125 percent.

Securities held by the Vaccine Injury Compensation Trust Fund (funds from dedicated collections) will mature in FY 2016 through FY 2020. The Market-Based Notes paid from 1.0 percent to 3.875 percent during October 1, 2014 to September 30, 2015 and 1.0 percent to 4.125 percent during October 1, 2014 to September 30, 2015. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market Based Bills held in the NIH gift funds held during the 12 months of FY 2015 yielded from 0.005 percent to 0.2253 percent depending on the date purchased and the time to maturity.

The investments held by the CHIP Child Enrollment Contingency Fund in the amount of \$2.1 billion as of September 30, 2015 are short term Non-Marketable Market-Based Bills purchased at a discount which are fully amortized at the maturity date.

**Note 5. Accounts Receivable, Net (in Millions)**

<u>2015</u>	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
<i>Intragovernmental</i>					
Entity	\$ 1,002	\$ -	\$ 1,002	\$ -	\$ 1,002
Non-Entity	3	-	3	-	3
<b>Total, Intragovernmental</b>	<b>\$ 1,005</b>	<b>\$ -</b>	<b>\$ 1,005</b>	<b>\$ -</b>	<b>\$ 1,005</b>
<i>With the Public</i>					
Entity					
Medicare	\$ 8,806	\$ -	\$ 8,806	\$ (2,031)	\$ 6,775
Other	16,713	269	16,982	(1,869)	15,113
Non-Entity	-	53	53	(26)	27
<b>Total With the Public</b>	<b>\$ 25,519</b>	<b>\$ 322</b>	<b>\$ 25,841</b>	<b>\$ (3,926)</b>	<b>\$ 21,915</b>

<u>2014</u>	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
<i>Intragovernmental</i>					
Entity	\$ 919	\$ -	\$ 919	\$ -	\$ 919
Non-Entity	-	-	-	-	-
<b>Total, Intragovernmental</b>	<b>\$ 919</b>	<b>\$ -</b>	<b>\$ 919</b>	<b>\$ -</b>	<b>\$ 919</b>
<i>With the Public</i>					
Entity					
Medicare	\$ 7,881	\$ -	\$ 7,881	\$ (1,649)	\$ 6,232
Other	5,558	7	5,565	(1,658)	3,907
Non-Entity	-	40	40	(20)	20
<b>Total With the Public</b>	<b>\$ 13,439</b>	<b>\$ 47</b>	<b>\$ 13,486</b>	<b>\$ (3,327)</b>	<b>\$ 10,159</b>

As of September 30, 2015, the other accounts receivable is primarily related to collections for Marketplace activities.

**Note 6. Inventory and Related Property, Net (in Millions)**

	2015	2014
Inventory Held for Current Sale, Net	\$ 7	\$ 8
Operating Materials and Supplies Held for Use	73	120
Stockpile Materials Held for Emergency or Contingency	9,436	8,478
<b>Inventory and Related Property, Net</b>	<b>\$ 9,516</b>	<b>\$ 8,606</b>



**Note 7. General Property, Plant and Equipment, Net (in Millions)**

	Depreciation Method	Estimated Useful Lives	2015		
			Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	\$ 53	\$ -	\$ 53
Construction in Progress	-	-	650	-	650
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	6,140	(2,788)	3,352
Equipment	Straight Line	3-20 Yrs	1,922	(1,134)	788
Internal Use Software	Straight Line	7-10 Yrs	1,955	(965)	990
Assets Under Capital Lease	Straight Line	1-30 Yrs	126	(59)	67
Leasehold Improvements	Straight Line	*Life of Lease	51	(34)	17
<b>Totals</b>			<b>\$ 10,897</b>	<b>\$ (4,980)</b>	<b>\$ 5,917</b>

	Depreciation Method	Estimated Useful Lives	2014		
			Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	\$ 53	\$ -	\$ 53
Construction in Progress	-	-	549	-	549
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	6,122	(2,615)	3,507
Equipment	Straight Line	3-20 Yrs	1,858	(1,149)	709
Internal Use Software	Straight Line	7-10 Yrs	1,827	(860)	967
Assets Under Capital Lease	Straight Line	1-30 Yrs	119	(55)	64
Leasehold Improvements	Straight Line	*Life of Lease	51	(32)	19
<b>Totals</b>			<b>\$ 10,579</b>	<b>\$ (4,711)</b>	<b>\$ 5,868</b>

\*7 to 15 years or the life of the lease, whichever is shorter.

**Note 8. Other Assets (in Millions)**

	2015	2014
<i>Intragovernmental</i>		
Advances to Other Federal Entities	\$ 178	\$ 95
<i>With the Public</i>		
Travel Advances & Emergency Employee Salary Advances	\$ 5	\$ -
Other Payments & Deferred Changes	28	21
Direct Loan	1,112	769
Other	9	20
<b>Total With the Public</b>	<b>\$ 1,154</b>	<b>\$ 810</b>

**Note 9. Liabilities Not Covered by Budgetary Resources (in Millions)**

	2015	2014
<i>Intragovernmental</i>		
Accrued Payroll and Benefits	\$ 58	\$ 60
Other	1,699	748
<b>Total Intragovernmental</b>	<b>\$ 1,757</b>	<b>\$ 808</b>
Federal Employee and Veterans' Benefits (Note 11)	12,072	11,979
Accrued Payroll and Benefits	632	620
Contingencies and Commitments (Note 14)	9,105	11,332
Other Accrued Liabilities (Note 12)	10,419	-
Other	210	152
<b>Total Liabilities Not Covered by Budgetary Resources</b>	<b>\$ 34,195</b>	<b>\$ 24,891</b>
<b>Total Liabilities Covered by Budgetary Resources</b>	<b>117,193</b>	<b>99,250</b>
<b>Total Liabilities</b>	<b>\$ 151,388</b>	<b>\$ 124,141</b>

**Note 10. Entitlement Benefits Due and Payable (in Millions)**

	2015	2014
Medicare FFS	\$ 45,268	\$ 41,311
Medicaid Advantage/Prescription Drug Program	20,953	16,280
Medicaid	36,758	32,275
CHIP	773	923
Other	4,397	248
<b>Totals</b>	<b>\$ 108,149</b>	<b>\$ 91,037</b>

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage/Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

The Medicare fee-for-service liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for

payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current FY but paid in the subsequent FY and (e) an estimate of retroactive settlements of cost reports. The September 30, 2015 and 2014 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2015. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2015.

The Medicaid and CHIP estimates represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS.

The Other liability line item includes estimates of payments due to those participating in Marketplace activities.

#### **Note 11. Federal Employee and Veterans' Benefits (in Millions)**

	2015	2014
<i>With the Public</i>		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	\$ 11,227	\$ 11,154
PHS Commissioned Corp Post-retirement Health Benefits	574	537
Workers' Compensation Benefits (Actuarial FECA Liability)	271	288
<b>Total Federal Employee and Veterans' Benefits</b>	<b>\$ 12,072</b>	<b>\$ 11,979</b>

#### **PHS Commissioned Corps**

HHS administers the PHS Commissioned Corps Retirement System for 6,668 active duty officers and 6,595 retiree annuitants and survivors. As of September 30, 2015, the actuarial accrued liability for the retirement benefit plan was \$11.2 billion and \$0.6 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commissioned Corp Retirement System and Post-Retirement Benefits are not funded. Therefore, in accordance with SFFAS Number 33, *Pensions, Other Retirement Benefits and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates* (SFFAS Number 33), the discount rate should be based on long-term assumptions, for marketable securities (such as Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates should be matched with the expected timing of the associated expected cash flow. A single discount rate may be used for all the projected cash flows, if the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2015 and September 30, 2014, were:

	2015	2014
Interest on federal securities	4.44 percent	4.65 percent
Annual basic pay scale increase	2.68 percent	2.93 percent
Annual inflation	2.18 percent	2.43 percent

The following shows key valuation results as of September 30, 2015 and 2014, in conformance with the actuarial reporting standards set forth in the SFFAS Number 5, *Accounting for Liabilities of the Federal Government* and SFFAS Number 33. The valuation is based upon the current plan provisions, membership data collected as of June 30, 2015, and actuarial assumptions. The September 30, 2015 valuation includes an increase in liabilities of \$110 million resulting from an increase in costs and an actuarial loss from changes in assumptions and experience. Volatility of the discount rate significantly affects the liabilities for these benefits. To mitigate the impact of this volatility, SFFAS Number 33 also provides for the use of historical average rates to prevent the undue influence of current or near term rates.

	2015	2014
Beginning Liability Balance	\$ 11,691	\$ 11,273
Expense		
Normal Cost	321	274
Interest on the liability balance	508	517
Actuarial (Gain)/Loss		
From experience	(98)	(63)
From assumption changes		
Change in discount rate assumption	326	2
Change in inflation/salary increase assumption	(508)	44
Change in Others	31	99
Net Actuarial (Gain)/Loss	(249)	82
Total expense	\$ 580	\$ 873
Less amounts paid	(470)	(455)
Ending Liability Balance	\$ 11,801	\$ 11,691

### Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. In FY 2015, the fund effected a change in accounting estimate to refine the methodology used for selecting the interest rate assumptions and enhance matching between the timing of cash flows and interest rates. For FY 2015, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues (the TNC Yield Curve) for the current and prior four years; for FY 2014, discount rates were based on the TNC Yield Curve for one year. Interest rate assumptions utilized for discounting as of September 30, 2015 and September 30, 2014 follow.

	2015	2014
Wage Benefits	3.134% in Year 1 3.134% in Year 2 and thereafter	3.455% in Year 1 3.455% in Year 2 and thereafter
Medical Benefits	2.496% in Year 1 2.496% in Year 2 and thereafter	2.855% in Year 1 2.855% in Year 2 and thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors, cost of living adjustments (COLA) and medical inflation factors such as consumer price index-medical (CPIM) are applied to the calculations for projected future benefits. These factors are also used to adjust historical payments to current year dollars. The anticipated percentages for COLA and CPIM used in projections are:

FY	COLA	CPIM
2015	N/A	N/A
2016	1.64%	2.94%
2017	1.47%	2.98%
2018	1.33%	3.09%
2019	1.43%	3.39%
2020	1.65%	3.69%

#### Note 12. Accrued Liabilities (in Millions)

	2015	2014
Estimated Accrual for Amounts Due to Grantees	\$ 22,103	\$ 21,641
Offsetting Grant Advances	(18,272)	(18,327)
Other Accrued Liabilities	10,419	-
<b>Total Accrued Liabilities</b>	<b>\$ 14,250</b>	<b>\$ 3,314</b>

#### Note 13. Other Liabilities (in Millions)

	2015		2014	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	\$ 118	\$ 969	\$ 109	\$ 918
Advances from Others	446	720	339	106
Deferred Revenue	-	642	-	483
Custodial Liabilities	729	12	934	15
Legal Liabilities (Note 14)	941	-	707	-
Other	1,375	977	933	979
<b>Total Other Liabilities</b>	<b>\$ 3,609</b>	<b>\$ 3,320</b>	<b>\$ 3,022</b>	<b>\$ 2,501</b>

## Note 14. Contingencies and Commitments

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HHS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the federal government. HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible and an estimate can be determined or an estimate of the range of possible liability has been determined. Selected contingencies and commitments are described below.

### Medicaid Audit and Program Disallowances

The Medicaid amount of \$7.5 billion (\$8.5 billion in FY 2014) consists of Medicaid audit and program disallowances of \$2.4 billion (\$2.9 billion in FY 2014) and \$5.1 billion (\$5.6 billion in FY 2014) for reimbursement of State Plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. In all cases, the funds have been returned to HHS. HHS will be required to pay these amounts if the appeals are decided in favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made.

### Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability. As of September 30, 2015, 9,737 cases (9,311 in FY 2014) remain on appeal. A total of 3,473 new cases were filed (4,400 in FY 2014) and 9 cases were reopened (12 in FY 2014). The PRRB rendered decisions on 84 cases in FY 2015 (73 in FY 2014); and 2,972 additional cases (2,152 in FY 2014) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB receives no information on the value of cases that are settled prior to a hearing.

### Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in *Salazar v. Ramah Navajo Chapter*, dated June 18, 2012, is likely to result in additional claims against the IHS. As a result of this decision, many tribes have filed claims. Some claims have been paid and others have been asserted but not yet settled. It is expected that some tribes will file additional claims for prior years. An estimated loss related to this matter was accrued last year and the remaining unpaid accrued liability is included on the Consolidated Balance Sheet.

The Vaccine Injury Compensation Program is administered by HRSA and provides compensation for vaccine-related injury or death. A contingent liability has been accrued in the financial statements for the estimated future payment of injury claims.

**Note 15. Revenue (in Millions)****2015 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification**

	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
<i>Intragovernmental</i>							
Gross Cost	\$ 122	\$ 6,517	\$ 1,026	\$ 20	\$ 7,685	\$ (2,548)	\$ 5,137
Exchange Revenue	(33)	(3,116)	(12)	(7)	(3,168)	2,344	(824)
Net Cost, <i>Intragovernmental</i>	\$ 89	\$ 3,401	\$ 1,014	\$ 13	\$ 4,517	\$ (204)	\$ 4,313
<i>With the Public</i>							
Gross Cost	\$ 13,978	\$ 453,400	\$ 621,810	\$ 38,002	\$ 1,127,190	\$ -	\$ 1,127,190
Exchange Revenue	-	(25,769)	(75,689)	(16)	(101,474)	-	(101,474)
Net Cost, <i>With the Public</i>	\$ 13,978	\$ 427,631	\$ 546,121	\$ 37,986	\$ 1,025,716	\$ -	\$ 1,025,716
Total Gross Cost	\$ 14,100	\$ 459,917	\$ 622,836	\$ 38,022	\$ 1,134,875	\$ (2,548)	\$ 1,132,327
Total Exchange Revenue	(33)	(28,885)	(75,701)	(23)	(104,642)	2,344	(102,298)
Total Net Cost of Operations	\$ 14,067	\$ 431,032	\$ 547,135	\$ 37,999	\$ 1,030,233	\$ (204)	\$ 1,030,029

**2014 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification**

	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
<i>Intragovernmental</i>							
Gross Cost	\$ 158	\$ 7,059	\$ 1,052	\$ 87	\$ 8,356	\$ (2,935)	\$ 5,421
Exchange Revenue	(53)	(3,555)	(16)	(12)	(3,636)	2,741	(895)
Net Cost, <i>Intragovernmental</i>	\$ 105	\$ 3,504	\$ 1,036	\$ 75	\$ 4,720	\$ (194)	\$ 4,526
<i>With the Public</i>							
Gross Cost	\$ 13,025	\$ 385,456	\$ 589,581	\$ 37,583	\$ 1,025,645	\$ -	\$ 1,025,645
Exchange Revenue	-	(5,607)	(72,551)	(31)	(78,189)	-	(78,189)
Net Cost, <i>With the Public</i>	\$ 13,025	\$ 379,849	\$ 517,030	\$ 37,552	\$ 947,456	\$ -	\$ 947,456
Total Gross Cost	\$ 13,183	\$ 392,515	\$ 590,633	\$ 37,670	\$ 1,034,001	\$ (2,935)	\$ 1,031,066
Total Exchange Revenue	(53)	(9,162)	(72,567)	(43)	(81,825)	2,741	(79,084)
Total Net Cost of Operations	\$ 13,130	\$ 383,353	\$ 518,066	\$ 37,627	\$ 952,176	\$ (194)	\$ 951,982

**Exchange Revenue**

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was \$102.3 billion and \$79.1 billion through September 30, 2015 and 2014, respectively. HHS's exchange revenue consists primarily of Medicare premiums collected from beneficiaries. HHS also charges user fees and collects revenues related to reimbursable agreements with other government entities.

## Note 16. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances at year end on the Statement of Budgetary Resources consist of Trust Funds, appropriated funds, revolving funds, management funds, gift funds, Cooperative Research and Development Agreement funds and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All Trust Fund receipts collected in the FY are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of trust fund receipts collected in the FY that exceeds the amount needed to pay benefits and other valid obligations in that FY is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the FY collected. However, all such excess receipts are assets of the Trust Funds and become available for obligation as needed. The entire Trust Fund balances in the amount of \$201.1 billion as of September 30, 2015, (\$225.0 billion in FY 2014) are included in Investments on the Consolidated Balance Sheets.

### **Exempt from Apportionment**

This amount includes the FY 2015 recording of obligations required by law where such obligations are in excess of available funding. These obligations were incurred by operation of law; thus, they are reflected as exempt from apportionment. The *Anti-Deficiency Act* has not been violated, as "[t]he prohibitions contained in the *Anti-Deficiency Act* are directed at discretionary obligations entered into by administrative officers."

B-219161 (Oct. 2 1985).

## Note 17. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

The Budget of the U.S. Government (also known as the President's Budget), with the actual amounts for FY 2015, has not been published, therefore, no comparisons can be made between FY 2015 amounts presented in the Statement of Budgetary Resources with amounts reported in the Actual column of the President's Budget. The FY 2017 President's Budget is expected to be released in February 2016 and may be obtained from OMB's website, [www.whitehouse.gov/omb/budget](http://www.whitehouse.gov/omb/budget), or from the Government Printing Office.

HHS reconciled the amounts of the FY 2014 column on the Statement of Budgetary Resources to the actual amounts for FY 2014 from the Appendix in the FY 2016 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections) as presented below.

2014	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Outlays, net (total) (discretionary and mandatory)
Statement of Budgetary Resources	\$ 1,412,259	\$ 1,374,378	\$ 359,650	\$ 1,297,031
Expired Accounts	(7,998)	77	-	64
Other	(934)	152	860	(170)
Budget of the U.S. Government	\$ 1,403,327	\$ 1,374,607	\$ 360,510	\$ 1,296,925

For the budgetary resources reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Statement of Budgetary Resources and not in the President's Budget is the budgetary resources that were not available. The "Expired



Accounts" line in the above schedule includes expired authority, recoveries and other amounts included in the Combined Statement of Budgetary Resources that are not included in the President's Budget.

The "Other" differences in the budgetary resources and obligations incurred are due to gift funds are reported on the HHS Statement of Budgetary Resources but not in the President's Budget. Government-wide Treasury Account Symbol Adjusted Trial Balance System revision window adjustments were not included in the HHS Statement of Budgetary Resources but included in the President's Budget. In addition, return of cancelled year funds and adjustments made to reclassify recoveries.

**Note 18. Apportionment Categories of Obligations Incurred and Undelivered Orders (in Millions)**

	2015		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	\$ 95,359	\$ 7,487	\$ 102,846
Category B (Restricted and Distributed by Activity)	700,591	3,832	704,423
Exempt from Apportionment	670,199	13	670,212
<b>Total Obligations Incurred</b>	<b>\$ 1,466,149</b>	<b>\$ 11,332</b>	<b>\$ 1,477,481</b>

	2014		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	\$ 94,625	\$ 8,084	\$ 102,709
Category B (Restricted and Distributed by Activity)	628,534	3,004	631,538
Exempt from Apportionment	640,113	18	640,131
<b>Total Obligations Incurred</b>	<b>\$ 1,363,272</b>	<b>\$ 11,106</b>	<b>\$ 1,374,378</b>

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from OMB Circular Number A-11, *Preparation, Submission and Execution of the Budget*, requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the Standard Form 133, *Report on Budget Execution and Budgetary Resources*.

Undelivered Orders include obligations that have been issued but are not yet drawn down and goods and services ordered that have not been received. HHS reported \$105.8 billion of budgetary resources obligated for undelivered orders as of September 30, 2015 and \$117.0 billion as of September 30, 2014.

**Note 19. Funds from Dedicated Collections (in Millions)**

Medicare is the largest dedicated collections fund group managed by HHS and is presented in a separate column in the schedule below. The Medicare program includes the HI Trust Fund; the SMI Trust Fund which includes both Part B medical insurance and the Prescription Drug Benefit – Part D; and the Medicare Integrity Program. Portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds. See [Note 1](#) for a description of each fund's purpose and how HHS accounts for and reports the fund.

	2015		
	Medicare	Other	Total
<b>Balance Sheet as of September 30</b>			
Fund Balance with Treasury	\$ 44,785	\$ 6,598	\$ 51,383
Investments	263,993	3,606	267,599
Other Assets	7,327	10,661	17,988
<b>Total Assets</b>	<b>\$ 316,105</b>	<b>\$ 20,865</b>	<b>\$ 336,970</b>
Entitlement Benefits Due and Payable	\$ 66,221	\$ 4,195	\$ 70,416
Accrued Liabilities ( <a href="#">Note 12</a> )	-	10,419	10,419
Other Liabilities	3,021	1,450	4,471
<b>Total Liabilities</b>	<b>\$ 69,242</b>	<b>\$ 16,064</b>	<b>\$ 85,306</b>
Unexpended Appropriations	30,284	(100)	30,184
Cumulative Results of Operations	216,579	4,901	221,480
<b>Total Liabilities and Net Position</b>	<b>\$ 316,105</b>	<b>\$ 20,865</b>	<b>\$ 336,970</b>
<b>Statement of Net Cost for the Period Ended September 30</b>			
Gross Program Costs	\$ 622,836	\$ 26,545	\$ 649,381
Less: Exchange Revenues	75,701	23,813	99,514
<b>Net Cost of Operations</b>	<b>\$ 547,135</b>	<b>\$ 2,732</b>	<b>\$ 549,867</b>
<b>Statement of Changes in Net Position for the Period Ended September 30</b>			
Net Position Beginning of Period	\$ 237,110	\$ 6,656	\$ 243,766
Non-Exchange Revenue	252,045	338	252,383
Other Financing Sources	304,843	539	305,382
Net Cost of Operations	(547,135)	(2,732)	(549,867)
Change in Net Position	\$ 9,753	\$ (1,855)	7,898
<b>Net Position End of Period</b>	<b>\$ 246,863</b>	<b>\$ 4,801</b>	<b>\$ 251,664</b>

**Balance Sheet as of September 30**

	2014		
	Medicare	Other	Total
Fund Balance with Treasury	\$ 19,189	\$ 3,581	\$ 22,770
Investments	273,286	3,513	276,799
Other Assets	7,225	221	7,446
<b>Total Assets</b>	<b>\$ 299,700</b>	<b>\$ 7,315</b>	<b>\$ 307,015</b>
Entitlement Benefits Due and Payable	\$ 57,591	\$ -	\$ 57,591
Other Liabilities	4,999	659	5,658
<b>Total Liabilities</b>	<b>\$ 62,590</b>	<b>\$ 659</b>	<b>\$ 63,249</b>
Unexpended Appropriations	\$ 16,315	\$ (100)	\$ 16,215
Cumulative Results of Operations	220,795	6,756	227,551
<b>Total Liabilities and Net Position</b>	<b>\$ 299,700</b>	<b>\$ 7,315</b>	<b>\$ 307,015</b>

**Statement of Net Cost for the Period Ended September 30**

Gross Program Costs	\$ 590,633	\$ 1,109	\$ 591,742
Less: Exchange Revenues	72,567	2,655	75,222
<b>Net Cost of Operations</b>	<b>\$ 518,066</b>	<b>\$ (1,546)</b>	<b>\$ 516,520</b>

**Statement of Changes in Net Position for the Period Ended September 30**

Net Position Beginning of Period	\$ 242,714	\$ 5,751	\$ 248,465
Non-Exchange Revenue	242,701	307	243,008
Other Financing Sources	269,761	(948)	268,813
Net Cost of Operations	(518,066)	1,546	(516,520)
Change in Net Position	\$ (5,604)	\$ 905	\$ (4,699)
<b>Net Position End of Period</b>	<b>\$ 237,110</b>	<b>\$ 6,656</b>	<b>\$ 243,766</b>

## Note 20. Stewardship Land

IHS provides federal health services to American Indians and Alaska Natives to help raise their health status to the highest possible level. IHS provides health care to approximately 2.2 million American Indians and Alaska Natives who belong to 566 federally recognized tribes in 35 states. Health services are provided on tribal/reservation trust land that was transferred to IHS by the DOI for this purpose. Although the structures on this land are operational in nature, the land on which these structures reside is managed in a stewardship manner. The Department did not receive any additional stewardship land in FY 2015 or FY 2014. All trust land, when no longer needed by IHS, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight. In FY 2014, this information was included in the RSI.

The table below presents stewardship land held by HHS in number of sites:

**Indian Trust Land by Number of Sites and Location**

	2015/2014
Albuquerque	4
Bemidji	2
Billings	7
Great Plains	9
Navajo	35
Oklahoma City	1
Phoenix	12
Portland	3
Tucson	5
<b>Total</b>	<b>78</b>

## Note 21. Incidental Custodial Collections

HHS reports custodial activities on the Consolidated Balance Sheets; however, HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

The majority of the custodial collections is funding ACF receives from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds.

In FY 2015, the Department had custodial collections of \$2.1 billion of which \$1.9 billion was related to ACF. The Department made disbursements of \$2.1 billion of which \$1.9 billion was related to ACF.

**Note 22. Reconciliation of Net Cost of Operations (Proprietary) to Budget (in Millions)**

	2015	2014
<b>Resources Used to Finance Activities:</b>		
<b>Budgetary Resources Obligated</b>		
Obligations Incurred	\$ 1,477,481	\$ 1,374,378
Spending Authority from Offsetting Collections and Recoveries	(60,006)	(50,799)
Obligations Net of Offsetting Collections and Recoveries	1,417,475	1,323,579
Distributed Offsetting Receipts	(380,187)	(359,650)
Net Obligations	\$ 1,037,288	\$ 963,929
<b>Other Resources</b>		
Net Non-Budgetary Resources Used to Finance Activities	1,332	(445)
<b>Total Resources Used to Finance Activities</b>	<b>\$ 1,038,620</b>	<b>\$ 963,484</b>
<b>Resources Used to Finance Items Not Part of the Net Cost of Operations:</b>		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	\$ (10,625)	\$ 21,765
Resources That Fund Expenses Recognized in Prior Periods	43	33
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	9,965	(6,715)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	2,092	1,389
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	3,405	3,114
<b>Total Resources Used to Finance Items Not Part of the Net Cost of Operations</b>	<b>4,880</b>	<b>19,586</b>
<b>Total Resources Used to Finance the Net Cost of Operations</b>	<b>\$ 1,033,740</b>	<b>\$ 943,898</b>
<b>Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period</b>		
Components Requiring or Generating Resources in Future Periods	\$ (2,884)	\$ 3,399
Components Not Requiring or Generating Resources	(827)	4,685
<b>Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period</b>	<b>(3,711)</b>	<b>8,084</b>
<b>Net Cost of Operations</b>	<b>\$ 1,030,029</b>	<b>\$ 951,982</b>

**Note 23. Combined Schedule of Spending**

The Schedule of Spending presents an overview of how departments or agencies are spending (i.e., obligating) money. The Schedule of Spending presents total budgetary resources and total obligations incurred for the reporting entity. The data used to populate this schedule are the same underlying data used to populate the Combined Statement of Budgetary Resources. Simplified terms are used to improve the public's understanding of the budgetary accounting terminology used in the Statement of Budgetary Resources.

The Office of Management and Budget (OMB) makes available a searchable website, [www.USAspending.gov](http://www.USAspending.gov)<sup>5</sup>, that provides information on Federal awards of contracts and grants and is accessible to the public at no cost. When

<sup>5</sup> The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

comparing [www.USAspending.gov](http://www.USAspending.gov) data to the Schedule of Spending one must take into account that the website has a fundamentally different purpose and, as such, there are differences due to object classes not reported to [www.USAspending.gov](http://www.USAspending.gov) that include but are not limited to personnel compensation, travel, utilities and leases, intra-departmental and interagency spending, and various other categories of financial awards. In addition, the reporting entity between the financial statements and [www.USAspending.gov](http://www.USAspending.gov) differs for awards resulting from funding allocations between agencies, and/or HHS OpDivs. As a result, [www.USAspending.gov](http://www.USAspending.gov) data will differ from the Schedule of Spending.

**What Money is Available to Spend?** This section presents resources that were available to spend as reported in the Statement of Budgetary Resources. Total Resources refers to Total Budgetary Resources as described in the Statement of Budgetary Resources and represents amounts approved for spending by law. “Amounts Not Agreed to be Spent” represents amounts that HHS was allowed to spend but did not take action to spend by the end of the FY. “Amounts Not Available to Spend” represents amounts that HHS was not approved to spend during the current FY. “Total Amounts Agreed to be Spent” represents spending actions taken by HHS – including contracts, orders, grants, or other legally binding agreements of the federal government – to pay for goods or services. This line total agrees to the Obligations Incurred line in the Statement of Budgetary Resources.

**Who did the Money Go To?** This section identifies the recipient of the money, by federal and non-federal entities. Amounts in this section reflect “amount agreed to be spent” and agree to the Obligations Incurred line on the Statement of Budgetary Resources.

**How was the Money Spent/Issued?** This section presents services or items that were purchased, categorized by Treasury Symbol. Those Treasury Symbols that have a material impact on the Statement of Budgetary Resources are presented separately. Other Treasury Symbols, such as Child Support Enforcement and Family Support, Child Care Entitlement to States, Affordable Insurance Exchange Grants, and Child Care and Development Block Grant, are summarized under “Other Agency Budgetary Accounts.”

**Combined Schedule of Spending**  
As of September 30, 2015 and 2014  
(in Millions)

**What Money is Available to Spend:**

	2015	2014
Total Resources	\$ 1,543,105	\$ 1,412,259
Less Amount Available but Not Agreed to be Spent	23,828	29,423
Less Amount Not Available to be Spent	41,796	8,458
	<u>\$ 1,477,481</u>	<u>\$ 1,374,378</u>

**Who did the Money Go To:**

Federal	\$ 8,142	\$ 10,954
Non-Federal	1,469,339	1,363,424
	<u>\$ 1,477,481</u>	<u>\$ 1,374,378</u>

**Combined Schedule of Spending**  
As of September 30, 2015 and 2014  
(in Millions)

**How was the Money Spent/Issued:**

	2015	2014
<b>Medicaid</b>	\$ 378,897	\$ 329,020
Grants, Subsidies, and Contributions	375,142	325,548
Supplies and Materials	3,637	3,357
Other Contractual Services	101	96
Other	17	19
<b>Medicare Hospital Insurance</b>	285,074	278,971
Financial Assistance Direct Payments	277,004	272,336
Financial Transfers	8,068	6,630
Other	2	5
<b>Medicare Supplementary Medical Insurance</b>	281,640	264,059
Financial Assistance Direct Payments	276,841	258,024
Financial Transfers	4,755	5,982
Other	44	53
<b>Payments to Trust Funds</b>	262,902	258,726
Grants, Subsidies, and Contributions	195,385	225,295
Financial Transfers	67,445	33,431
Other	72	-
<b>Medicare Prescription Drug Benefit (Medicare Part D)</b>	80,583	71,581
Financial Assistance Direct Payments	80,429	71,581
Financial Transfers	154	-
<b>Taxation on Old-Age Survivors and Disability Insurance Benefits, HI</b>	20,208	18,066
Grants, Subsidies, and Contributions	20,208	18,066
<b>Temporary Assistance for Needy Families</b>	16,717	16,759
Grants, Subsidies, and Contributions	16,657	16,702
Other	60	57
<b>State Children's Health Insurance Program</b>	11,496	10,112
Grants, Subsidies, and Contributions	11,486	10,054
Other	10	58
<b>Children and Families Services</b>	10,545	9,894
Grants, Subsidies, and Contributions	10,121	9,455
Other Contractual Services	262	280
Personnel Compensation and Benefits	143	141
Other	19	18
<b>Transitional Reinsurance Program</b>	8,249	-
Financial Assistance Direct Payments	8,249	-
<b>Foster Care and Permanency</b>	7,387	7,428
Grants, Subsidies, and Contributions	7,360	7,393
Other	27	35
<b>Indian Health Service</b>	5,702	5,429
Grants, Subsidies, and Contributions	2,834	2,756
Personnel Compensation and Benefits	1,332	1,298
Other Contractual Services	803	813
Other	733	562
<b>National Cancer Institute</b>	5,386	4,997
Grants, Subsidies, and Contributions	3,609	2,981
Other Contractual Services	1,178	1,424
Personnel Compensation and Benefits	504	492
Other	95	100
<b>Primary Health Care</b>	5,112	3,929
Grants, Subsidies, and Contributions	4,794	3,652
Other Contractual Services	233	199
Other	85	78
<b>Other Agency Budgetary Accounts</b>	97,583	95,407
Grants, Subsidies, and Contributions	51,517	50,566
Other Contractual Services	23,778	25,301
Other	12,630	12,325
Financial Assistance Direct Payments	9,658	7,215
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 1,477,481</b>	<b>\$ 1,374,378</b>

## Note 24. Statement of Social Insurance (Unaudited)

The Statement of Social Insurance presents, for the 75-year projection period, the present values of the income and expenditures of the HI and SMI trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010-2011 Technical Review Panel.

The basis for the projections in the Trustees Report has changed since last year due to the enactment of the MACRA. The projections shown in last year's report reflected a projected baseline scenario, which assumed an override of the SGR payment provisions used to set physician fee schedule payments. Since MACRA repealed the SGR formula and replaced it with specified payment updates for physicians, the projections in this year's report are based on current law.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on July 22, 2015, with one exception, and do not reflect any actual or anticipated changes subsequent to that date. The one exception is that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the General Fund of the Treasury. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI, and transfers from state governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

The Part A present values in the Statement of Social Insurance exclude the income and expenditures for the roughly 1 percent of beneficiaries who are 65 or over but are uninsured because they do not meet the normal insured status or related requirements to qualify for entitlement to Part A benefits. The primary purpose of the Statement of Social Insurance is to compare the projected future costs of Medicare with the program's scheduled revenues. Since costs for the uninsured are separately funded either through general revenue appropriations or through premium payments, the exclusion of such amounts does not materially affect the financial balance of Part A. In addition, such individuals are granted coverage outside of the social insurance framework underlying Medicare Part A. For these reasons, it is appropriate to exclude their income and expenditures from the Statement of Social Insurance.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to



become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

The Statement of Social Insurance sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The Statement of Social Insurance also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the Statement of Social Insurance also sets forth the same calculation for the closed group of participants. The closed group consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the Statement of Social Insurance. Moreover, these differences could affect the long-term sustainability of this social insurance program.

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on July 22, 2015, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. In addition, the estimates depend on many economic, demographic, and health care-specific assumptions, including changes in per beneficiary health care cost, wages, and the CPI, fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2015 Statement of Social Insurance actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2015. Specific assumptions are made for each of the different types of service provided by the Medicare program (e.g., hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more

detailed assumptions. Detailed information, similar to that denoted within Table 1, for the prior years is publicly available on the CMS website at [www.cms.hhs.gov/CFORReport](http://www.cms.hhs.gov/CFORReport).<sup>6</sup>

**Table 1: Significant Assumptions and Summary Measures Used  
for the Statement of Social Insurance 2015**

	Fertility rate <sup>1</sup>	Net immigration <sup>2</sup>	Mortality rate <sup>3</sup>	Real-wage differential <sup>4</sup>	Annual percentage change in:						Real- interest rate <sup>9</sup>
					Wages <sup>5</sup>	CPI <sup>6</sup>	Real GDP <sup>7</sup>	Per beneficiary cost <sup>8</sup>			
								HI	SMI		
									B	D	
2015	1.91	1,465,000	771.3	3.18	3.38	0.20	3.3	-0.9	2.2	2.5	2.1
2020	2.04	1,395,000	730.1	1.73	4.43	2.70	2.7	4.2	5.9	5.7	2.4
2030	2.00	1,190,000	667.6	1.23	3.93	2.70	2.1	4.4	4.9	5.1	2.9
2040	2.00	1,135,000	615.0	1.20	3.90	2.70	2.2	4.9	4.1	4.9	2.9
2050	2.00	1,110,000	568.9	1.21	3.91	2.70	2.1	3.9	3.7	4.8	2.9
2060	2.00	1,095,000	528.2	1.16	3.86	2.70	2.0	3.7	3.7	4.6	2.9
2070	2.00	1,085,000	492.2	1.11	3.81	2.70	2.1	3.9	3.7	4.5	2.9
2080	2.00	1,085,000	460.1	1.13	3.83	2.70	2.1	3.9	3.7	4.5	2.9

<sup>1</sup>Average number of children per woman.  
<sup>2</sup>Includes legal immigration, net of emigration, as well as other, non-legal, immigration.  
<sup>3</sup>The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.  
<sup>4</sup>Difference between percentage increases in wages and the CPI.  
<sup>5</sup>Average annual wage in covered employment.  
<sup>6</sup>Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.  
<sup>7</sup>The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.  
<sup>8</sup>These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.  
<sup>9</sup>Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the Statement of Social Insurance are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. These ultimate values assumed for the current year and the prior four years, based on the intermediate assumptions of the respective Medicare Trustees Reports, are summarized in Table 2.

<sup>6</sup> The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

**Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance  
FY 2015-2011**

Annual percentage change in:											
	Fertility rate <sup>1</sup>	Net immigration <sup>2</sup>	Mortality rate <sup>3</sup>	Real-wage differential <sup>4</sup>	Wages <sup>5</sup>	CPI <sup>6</sup>	Real GDP <sup>7</sup>	Per beneficiary cost <sup>8</sup>			Real-interest rate <sup>9</sup>
								HI	SMI		
									B	D	
FY 2015	2.0	1,085,000	460.1	1.13	3.83	2.70	2.1	3.9	3.7	4.5	2.9
FY 2014	2.0	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9
FY 2013	2.0	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	3.8	4.5	2.9
FY 2012	2.0	1,030,000	446.0	1.12	3.92	2.80	2.0	3.7	3.8	4.5	2.9
FY 2011	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9

<sup>1</sup>Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 13<sup>th</sup> year of the projection period.

<sup>2</sup>Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate level of net legal immigration is 790,000 persons per year, and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.

<sup>3</sup>The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

<sup>4</sup>Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in Table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.

<sup>5</sup>Average annual wage in covered employment. The value presented is the average annual percentage change from the 10<sup>th</sup> year of the 75-year projection period to the 75<sup>th</sup> year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.

<sup>6</sup>Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

<sup>7</sup>The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

<sup>8</sup>These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

<sup>9</sup>Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10<sup>th</sup> year of each projection period.

## Note 25. Alternative Statement of Social Insurance Projections (Unaudited)

The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. This scenario assumes that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the specified physician updates put in place by MACRA—will occur as current law requires. The Board of Trustees believes that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. The ability of health care providers to sustain the price reductions for those providers impacted by the productivity adjustments and the specified updates to physician payments will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. By the end of the long-range projection period, Medicare prices for many services would be less than half of their level without consideration of the productivity price reductions, and physician payments would be 30 percent lower than they would have been under the SGR. Before such an outcome would occur, lawmakers would likely intervene to

prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result. Overriding the productivity adjustments and specified physician updates, as lawmakers have done repeatedly in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent and, starting in 2024, physician payments transition from a payment update of 0.0 percent to an increase of 2.3 percent. In addition, the illustrative alternative also assumes that requirements for the Independent Payment Advisory Board would not be implemented.<sup>7</sup> This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

The table below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

### Medicare Present Values

(in Billions)

	Current law (Unaudited)	Alternative scenario <sup>1, 2</sup> (Unaudited)
Income		
Part A	\$17,902	\$17,929
Part B	23,995	29,605
Part D	10,156	10,246
Expenditures		
Part A	21,089	25,824
Part B	23,995	29,605
Part D	10,156	10,246
Income less expenditures		
Part A	(3,187)	(7,895)
Part B	-	-
Part D	-	-
<sup>1</sup> These amounts are not presented in the 2015 Trustees Report. <sup>2</sup> At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections that differs from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.		

The difference between the current law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.1 percent reduction in annual cost growth each year for these providers. If the productivity adjustments were gradually phased out and physician updates transitioned to the Medicare Economic Index update of 2.3 percent, as illustrated under the alternative scenario,

<sup>7</sup> The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *Affordable Care Act*. The assumption regarding physician payments is being used because the SGR was replaced earlier this year.

the estimated present value of Part A and Part B expenditures would be higher than the current law projections by roughly 22 percent and 23 percent, respectively. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario; and the present value of Part B income is also 23 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected by the productivity adjustments or the physician updates. The very minor impact is the result of a slight change in the discount rates that are used to calculate the present values.

The extent to which actual future Part A and Part B costs exceed the projected amounts due to changes to the productivity adjustments and physician updates depends on what specific changes might be legislated and whether Congress would pass further provisions to help offset such costs. As noted, these examples reflect only hypothetical changes to provider payment rates.

### **Note 26. Statement of Changes in Social Insurance Amounts (Unaudited)**

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future noninterest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The Statement of Changes in Social Insurance Amounts shows the reconciliation from the period beginning on January 1, 2014 to the period beginning on January 1, 2015, and the reconciliation from the period beginning on January 1, 2013 to the period beginning on January 1, 2014. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated future expenditures has the same effect on estimated total future income, and vice versa. Therefore, any change has no impact on the estimated future net cash flow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

The five changes considered in the Statement of Changes in Social Insurance Amounts are, in order:

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and health care assumptions, and
- changes in law.

All estimates in the Statement of Changes in Social Insurance Amounts represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

## Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the Statement of Changes in Social Insurance Amounts are for the current and prior year and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of Note 24 summarizes these assumptions for the current year.

### Period beginning on January 1, 2014 and ending January 1, 2015

Present values as of January 1, 2014 are calculated using interest rates from the intermediate assumptions of the 2014 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2015. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the 2014 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2015 Trustees Report.

### Period beginning on January 1, 2013 and ending January 1, 2014

Present values as of January 1, 2013 are calculated using interest rates from the intermediate assumptions of the 2013 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2014. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the 2013 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2014 Trustees Report.

## Change in the Valuation Period

### From the period beginning on January 1, 2014 to the period beginning on January 1, 2015

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2014-88) to the current valuation period (2015-89) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cash flow for 2014 and replaces it with a much larger negative net cash flow for 2089. The present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2014-88 to 2015-89. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2014 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

### From the period beginning on January 1, 2013 to the period beginning on January 1, 2014

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2013-87) to the current valuation period (2014-88) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cash flow for 2013 and replaces it with a much larger negative net cash flow for 2088. The present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2013-87 to 2014-88. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior

valuation for the year 2013 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

### **Change in Projection Base**

#### **From the period beginning on January 1, 2014 to the period beginning on January 1, 2015**

Actual income and expenditures in 2014 were different than what was anticipated when the 2014 Trustees Report projections were prepared. Part A income was very slightly lower and expenditures were very slightly higher than anticipated, based on actual experience. Part B total income and expenditures were also higher than estimated based on actual experience. For Part D, actual income and expenditures were both higher than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2014 and January 1, 2015 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

#### **From the period beginning on January 1, 2013 to the period beginning on January 1, 2014**

Actual income and expenditures in 2013 were different than what was anticipated when the 2013 Trustees Report projections were prepared. Part A income was slightly higher and expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were also lower than estimated based on actual experience. For Part D, actual income and expenditures were both slightly higher on an incurred basis than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2013 and January 1, 2014 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

### **Changes in the Demographic Assumptions**

#### **From the period beginning on January 1, 2014 to the period beginning on January 1, 2015**

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2015) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2012 and preliminary data for 2013 indicated lower birth rates than were expected in the prior valuation. In this year's projections the total fertility rate reaches the ultimate in 2027, which is eleven years earlier than in last year's projections.
- Incorporating mortality data obtained from Medicare experience at ages 65 and older for 2012 resulted in slightly higher death rates for 2012 and a slightly slower rate of decline in mortality over the next 25 years than were projected last year. Incorporating mortality data obtained from the National Centers for Health Statistics at ages under 65 for 2011 resulted in slightly lower death rates for 2011 and a slightly faster rate of decline in mortality over the next 25 years than were projected last year.
- Historical legal immigration was revised to include single age data (rather than 5-year age groups); including more recent marriage, legal immigration, and other-than-legal immigration data; historical data since 2001 was revised to be more consistent with the most recent estimates from the Census Bureau.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cash flow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.



**From the period beginning on January 1, 2013 to the period beginning on January 1, 2014**

The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2014) are the same as those for the prior valuation. However, the starting demographic values, and the way these values transition to the ultimate assumptions, were changed.

- Preliminary birth rate data for 2012 indicated lower birth rates than were expected in the prior valuation. During the period of transition to their ultimate values, the birth rates in the current valuation are generally lower than they were in the prior valuation.

There was one change in demographic methodology:

- The modeling of the other immigrant population was divided into three distinct groups for the current valuation: (1) those with temporary legal status; (2) those never authorized to be in the country; and (3) those who had temporary legal status previously but are no longer authorized to be in the country.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cash flow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.

A further assumption change was made that resulted in higher Part D enrollment for the current valuation period. The participation rate represents the percentage of beneficiaries assumed to enroll in a Part D plan out of all eligible and, in prior years, was assumed to stay relatively constant at the same rate as the recent historical period. However, since actual participation has consistently been higher than expected, it was decided to increase the participation rate by 1 percent per year for the first three years of the projection period before leveling out. This results in an assumed 62.4 percent participation rate, prior to adjustments for beneficiaries who have retiree drug subsidy coverage and those who are assumed to drop out because they are required to pay an income-related premium, for 2017 and later, which is higher than the 57.2 percent that was assumed for all years in the prior valuation period. This assumption change resulted in an increase in the present value of estimated future income and estimated future expenditures for Part D, and had no impact on the Part A and Part B present values.

**Changes in Economic and Health Care Assumptions****For the period beginning on January 1, 2014 to the period beginning on January 1, 2015**

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2015), there was one change to the ultimate economic assumptions.

- The ultimate real-wage differential is assumed to be 1.17 percent in the current valuation period, compared to 1.13 percent in the previous valuation period.

The higher real wage differential assumption is more consistent with recent experience and expectations of slower growth in employer sponsored group health insurance premiums from the Office of the Actuary at the CMS. Because these premiums are not subject to the payroll tax, slower growth in these premiums means that a greater share of employee compensation will be in the form of wages that are subject to the payroll tax.



Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed.

- The ratio of average taxable earnings to the average wage averages about 0.6 percentage point higher during the long-range period, compared to the previous valuation period.
- The projected suspense file contains fewer wage items, which is consistent with having fewer workers (many of whom are undocumented immigrants) with wages on the suspense file and more of these workers with earnings in the underground economy, compared to the previous valuation.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Lower long-range growth rate assumptions.
- Utilization rate assumptions for inpatient hospital services were decreased.
- Lower assumed hospice spending.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Introduction of high-cost specialty drugs used to treat hepatitis C.

The net impact of these changes resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and income, with an overall increase in the estimated future net cash flow. For Part B and Part D, these changes decreased the present value of estimated future expenditures (and also income).

**For the period beginning on January 1, 2013 and the period beginning on January 1, 2014**

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

**For the current valuation (beginning on January 1, 2014), there was one change to the ultimate economic assumptions:**

- The ultimate annual rate of change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) is assumed to be 2.7 percent per year in the current valuation period, compared to 2.8 percent per year in the previous valuation period. Lowering the ultimate average annual increase in the CPI-W makes it more comparable to recent historical annual increases.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values, and the way these values transition to the ultimate assumptions, were changed.

- The ratio of average taxable earnings to the average wage index is lower by 1.9 percent in 2012 and 1.5 percent in 2013, compared to the previous valuation period.

There were two main changes in the economic methodology:

- Projected labor force participation rates for the older population are slightly lower for the current valuation in order to better reflect the difference in participation rates between never-married and married populations and the projected improvement in life expectancy.
- Different earnings levels are assigned to the three distinct groups of the other immigrant population supplied by demography. (This change decreased the present value of future cash flows by about the same amount as the related change in the demography methodology increased the present value of future cash flows.)

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- The projections emphasized in the 2014 Medicare Trustees Report were changed to reflect the projected baseline scenario. This scenario assumes that the physician payment updates required under the current-law sustainable growth rate formula will be overridden by lawmakers. The use of these projections increases the present value of estimated future expenditures, compared to the current law projections, for Part B by roughly 11 percent, and for total Medicare by about 5 percent.
- Utilization rate assumptions for inpatient hospital services were decreased.
- Case mix increase assumptions for skilled nursing facilities and home health agencies were decreased.
- Market basket differential for skilled nursing facilities was lowered.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Higher increases in productivity rates, resulting in lower payment updates.
- The methodology used to transition from the short-range projections to the long-range projections was refined, resulting in smaller increases during this transition period.
- Lower projected prescription drug trend rates.
- Higher assumed rebates from drug manufacturers.

The net impact of these changes resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in a decrease to the present value of estimated future expenditures and income, with an overall increase in the estimated future net cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of estimated future expenditures (and also income) for Part D.

## Changes in Law

### For the period beginning on January 1, 2014 to the period beginning on January 1, 2015

Although Medicare legislation was enacted since the prior valuation date, some of the provisions have a negligible impact on the present value of the 75-year estimated future income, expenditures, and net cash flow. The *Veteran's Access, Choice, and Accountability Act of 2014* established a temporary program that allows eligible veterans to receive hospital care and medical services from eligible providers outside of the Department of Veterans Affairs (VA) system, rather than waiting for a VA appointment or traveling to a VA facility. The *Improving Medicare Post-Acute Care Transformation Act of 2014* standardized the collection of data for post-acute providers and aligned the inflation of the hospice aggregate cap with that of hospice reimbursement. The *Tax Increase Prevention Act of 2014* accelerated the start date for the payment adjustment of misvalued codes under the physician fee schedule from 2017 to 2016, and delayed inclusion of oral-only end-stage renal disease (ESRD)-related drugs into the ESRD bundled payment system from 2024 to 2025. MACRA included many provisions affecting Medicare spending, including the repeal of the SGR formula for determining payments under the

physician fee schedule, the continuation of extensions for several provisions from prior legislation, a reduction in payment updates for most post-acute providers in 2018, the replacement of a 3.2 percent reduction to inpatient hospitals in 2018 with a 0.5 percent reduction in 2018 through 2023, and a revision to the income thresholds for determining the income-related monthly adjustment amounts under Part B and Part D.

Overall these provisions resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in a decrease to the present value of estimated future expenditures, with an overall increase in the estimated future net cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income). For Part D, the above-mentioned changes increased the present value of estimated future expenditures (and also income) only very slightly.

**For the period beginning on January 1, 2013 to the period beginning on January 1, 2014**

Although Medicare legislation was enacted since the prior valuation date, many of the provisions have a negligible impact on the present value of the 75-year estimated future income, expenditures, and net cash flow. The *Continuing Appropriations Resolution of 2014* included several provisions that had an impact on the MACRA program, including a 0.5 percent physician payment update for January through March of 2014, extension of the Medicare sequester to FY 2022 and 2023, and payment reform for long-term care hospitals. Further, sections 1 and 3 of Public Law 113-82 included a further extension of the Medicare sequester to FY 2024. Lastly, the *Protecting Access to Medicare Act of 2014* extended the 0.5 percent physician update through December 2014, enacted a 0 percent update for January through March of 2015, improved payment policy for clinical diagnostic lab tests, made revisions to the ESRD prospective payment system and physician fee schedule, and realigned the Medicare sequester in FY 2024. Overall these provisions resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures, with an overall increase in the estimated future net cash flow. For Part B, these changes lowered the present value of estimated future expenditures (and also income) only very slightly. For Part D, the above-mentioned changes increased the present value of estimated future expenditures (and also income) also very slightly.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

### Investment in Human Capital (in Millions)

For the Year Ended September 30, 2015

Responsibility Segment Program	2015	2014	2013	2012	2011
National Institutes of Health					
Research Training and Career Development	\$ 1,631	\$ 1,541	\$ 1,621	\$ 1,858	\$ 1,920
Health Resources and Services Administration					
Scholarships Loan Repayments and Loans	828	660	766	705	761
Other Investments in Human Capital					
Other	14	8	6	6	11
<b>Totals</b>	<b>\$ 2,473</b>	<b>\$ 2,209</b>	<b>\$ 2,393</b>	<b>\$ 2,569</b>	<b>\$ 2,692</b>

Investments in Human Capital are expenses incurred by federal education and training programs for the public, which are intended to maintain or increase national productive capacity. The following OpDivs conduct education and training programs under this category:

### National Institutes of Health

The NIH Research Training and Career Development Programs address the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the nation's health. NIH's major research training and career development programs include eight institutional training grants, five individual fellowships, 13 research career development awards, two research education grants, five loan repayment programs, and a variety of other training related programs. The 27 NIH institutes and centers administer NIH's major research training and career development programs. NIH's ability to maintain the momentum of recent scientific progress and international leadership in medical research depends upon the continued development of new, highly trained investigators.

### Health Resources and Services Administration

HRSA's Bureau of Health Workforce (BHW) improves the health of the nation's underserved communities and vulnerable populations by developing, implementing, evaluating, and refining programs that strengthen the nation's health care workforce. BHW programs holistically support a diverse, culturally competent workforce by addressing components including: education and training; recruitment and retention; financial support for students, faculty, practitioners, and supporting institutions; data analysis, and evaluation and coordination of global health workforce activities. These efforts support development of a skilled health workforce serving in areas of the nation with the greatest need. In FY 2015, BHW awarded more than \$1.0 billion to organizations and individuals. These funds were distributed among BHW's scholarships, loans, and loan repayment programs, health professions training programs, and programs supporting graduate medical education. Funding also supported the collection and analysis of health workforce data, which inform policies regarding health workforce supply and demand.

## Other Investments in Human Capital

Administered by ACL, Projects of National Significance grants are awarded to public and private non-profit institutions to enhance the independence, productivity, integration, and inclusion into the community of people with developmental disabilities. ACL also administers the Administration for Intellectual and Developmental Disabilities program. This program works to ensure that individuals with developmental disabilities and their families are able to fully participate in and contribute to all aspects of community life.

In addition, AHRQ provides an array of pre-doctoral and postdoctoral educational and career development grants and opportunities in health services research training. Research Training and Career Development activities are administered by the Division of Research Education in the Office of Extramural Research, Education, and Priority Populations.

### Investment in Research and Development (in Millions)

For the Year Ended September 30, 2015

Responsibility Segments	Basic	Applied	Develop-mental	2015 Total	2014	2013	2012	2011	Grand Total
AHRQ	\$ -	\$ 167	\$ -	\$ 167	\$ 250	\$ 372	\$ 401	\$ 333	\$ 1,523
CDC	73	391	26	490	394	457	408	457	2,206
FDA	123	-	6	129	103	94	80	58	464
NIH	16,856	11,237	-	28,093	27,719	29,328	30,681	32,902	148,723
Other	3	23	-	26	3	1	2	7	39
<b>Totals</b>	<b>\$ 17,055</b>	<b>\$ 11,818</b>	<b>\$ 32</b>	<b>\$ 28,905</b>	<b>\$ 28,469</b>	<b>\$ 30,252</b>	<b>\$ 31,572</b>	<b>\$ 33,757</b>	<b>\$ 152,955</b>

The research and development programs in HHS include the following:

### Agency for Healthcare Research and Quality

AHRQ is the leading federal agency charged with improving the safety and quality of America's health care system. AHRQ develops knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions. AHRQ supports health services research that will improve the quality of health care and promote evidence based decision making.

### Centers for Disease Control and Prevention

Diseases, Occupational Safety and Health, Health Promotion and Environmental Health and Injury Prevention were the primary areas where CDC's research and development was invested.

### Food and Drug Administration

FDA has two programs that meet the requirements of research and development investments: Orphan Products Development (OPD) Program and FDA Research Grants Program. While the FDA's center components conduct scientific studies, FDA does not consider this type of research as "research and development" because it is used to support FDA's regulatory policy and decision making processes.

The OPD Program was established by the *Orphan Drug Act* with the purpose of identifying orphan products and facilitating their development. An orphan product is a drug, biological product, medical device, or medical food that is intended to treat a rare disease or condition (i.e., one with a prevalence of fewer than 200,000 people in the U.S.).

The FDA Research Grants Program is a grants program whose purpose is to assist public and non-public institutions and for-profit organizations to establish, expand, and improve research, demonstration, education, and information dissemination activities concerned with a wide variety of FDA areas.


### National Institutes of Health

The NIH Research Program includes all aspects of the medical research continuum, including basic and disease-oriented research, observational and population-based research, behavioral research and clinical research, including research to understand both health and disease states, to move laboratory findings into medical applications, to assess new treatments or compare different treatment approaches, and health services research. NIH regards the expeditious transfer of the results of its medical research for further development and commercialization of products of immediate benefit to improved health as an important mandate.

NIH issues yearly research highlights in December each year. The highlights cover Clinical Advances/Breakthroughs, Promising Medical Advances, and Insights from the Lab. In 2014, NIH-funded research resulted in top scientific honors which includes one Nobel laureate in chemistry, and four NIH-funded recipients received awards from the Lasker Foundation. For more information on the yearly highlights, visit [www.nih.gov/research-training/nih-research-highlights](http://www.nih.gov/research-training/nih-research-highlights).

### Other Investments in Research and Development

ACF oversees research and development programs that contribute to a better understanding of how to improve the economic and social well-being of families and children, so that they may lead healthier and more productive lives. HRSA conducts health services research that will improve the quality of health care, increase capacity, and promote evidence-based decision making. HRSA's basic research supports the causes, diagnosis, prevention, and cure of Hansen's disease.



**DID YOU KNOW**

The 2015 Nobel Prize in chemistry was awarded to National Institutes of Health grantees Paul Modrich, Ph.D., of the Howard Hughes Medical Institute and the Duke University School of Medicine, Durham, N.C.; and Aziz Sancar, M.D., Ph.D., of the University of North Carolina, Chapel Hill, N.C., for having mapped, at a molecular level, how cells repair damaged DNA and safeguard the genetic information. NIH's National Institute of General Medical Sciences has supported the work of Dr. Sancar since 1982 and continuously supported the work of Dr. Modrich since 1972. Dr. Sancar's work has also been supported by the National Institute of Environmental Health Sciences, while the National Cancer Institute has also supported the work of Dr. Modrich.

**REQUIRED SUPPLEMENTARY INFORMATION**  
**Combining Statement of Budgetary Resources (in Millions)**  
For the Year Ended September 30, 2015

	CMS			Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
Budgetary Resources:	Medicare HI	Medicare SMI	Medicaid			
Unobligated Balance, Brought Forward, Oct 1	\$ -	\$ -	\$ 1,375	\$ 36,503	\$ 37,878	\$ 3
Recoveries of Prior Year Unpaid Obligations	13	-	22,148	4,219	26,380	-
Other Changes in Unobligated Balance	-	-	1	20,175	20,176	-
Unobligated Balance from Prior Year Budget Authority, Net	13	-	23,524	60,897	84,434	3
Appropriations (Discretionary and Mandatory)	285,049	270,457	351,098	519,003	1,425,607	-
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	-	50
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	12	11,183	763	20,973	32,931	80
<b>Total Budgetary Resources</b>	<b>\$ 285,074</b>	<b>\$ 281,640</b>	<b>\$ 375,385</b>	<b>\$ 600,873</b>	<b>\$ 1,542,972</b>	<b>\$ 133</b>
<b>Status of Budgetary Resources:</b>						
Obligations Incurred	\$ 285,074	\$ 281,640	\$ 375,051	\$ 535,585	\$ 1,477,350	\$ 131
Unobligated Balances, End of Year:						
Apportioned	-	-	205	26,244	26,449	-
Exempt from Apportionment	-	-	-	(2,621)	(2,621)	-
Unapportioned	-	-	129	41,665	41,794	2
Total Unobligated Balance, End of Year	-	-	334	65,288	65,622	2
<b>Total Status of Budgetary Resources</b>	<b>\$ 285,074</b>	<b>\$ 281,640</b>	<b>\$ 375,385</b>	<b>\$ 600,873</b>	<b>\$ 1,542,972</b>	<b>\$ 133</b>
<b>Change in Obligated Balance:</b>						
<b>Unpaid Obligation:</b>						
Unpaid Obligations, Brought Forward, Oct 1	\$ 29,502	\$ 22,816	\$ 35,406	\$ 128,442	\$ 216,166	\$ 998
Obligation Incurred	285,074	281,640	375,051	535,585	1,477,350	131
Outlays (Gross)	(281,947)	(280,975)	(346,737)	(521,325)	(1,430,984)	(754)
Actual Transfers, unpaid obligations (net)	-	-	-	196	196	-
Recoveries of Prior Year Unpaid Obligations	(13)	-	(22,148)	(4,219)	(26,380)	-
<b>Unpaid Obligations, End of Year</b>	<b>\$ 32,616</b>	<b>\$ 23,481</b>	<b>\$ 41,572</b>	<b>\$ 138,679</b>	<b>\$ 236,348</b>	<b>\$ 375</b>
<b>Uncollected Payments:</b>						
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	\$ -	\$ -	\$ -	\$ (11,838)	\$ (11,838)	\$ (430)
Adjustment to Uncollected Payments, Federal Sources	-	-	-	-	-	-
Change in Uncollected Customer Payments from Federal Sources	-	(11,172)	-	886	(10,286)	270
<b>Uncollected Payments from Federal Sources, End of Year</b>	<b>\$ -</b>	<b>\$ (11,172)</b>	<b>\$ -</b>	<b>\$ (10,952)</b>	<b>\$ (22,124)</b>	<b>\$ (160)</b>
<b>Memorandum (non-add) Entries:</b>						
Obligated Balance, Start of Year	\$ 29,502	\$ 22,816	\$ 35,406	\$ 116,604	\$ 204,328	\$ 568
Obligated Balance, End of Year	\$ 32,616	\$ 12,309	\$ 41,572	\$ 127,727	\$ 214,224	\$ 215

[1] "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of \$3.9 billion and net outlays of \$3.8 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

**Combining Statement of Budgetary Resources (Continued)** (in Millions)

	CMS				Agency Combined Budgetary Totals	Non- Budgetary Credit Reform Financing Account
	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[1]		
<b>Budget Authority and Outlays, Net:</b>						
Budget Authority, Gross (Discretionary and Mandatory)	\$ 285,061	\$ 281,640	\$ 351,861	\$ 539,976	\$ 1,458,538	\$ 130
Actual Offsetting Collections (Discretionary and Mandatory)	(13)	(10)	(763)	(22,474)	(23,260)	(350)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	-	(11,172)	-	886	(10,286)	270
<b>Budget Authority, Net (Discretionary and Mandatory)</b>	<b>\$ 285,048</b>	<b>\$ 270,458</b>	<b>\$ 351,098</b>	<b>\$ 518,388</b>	<b>\$ 1,424,992</b>	<b>\$ 50</b>
Outlays, Gross (Discretionary and Mandatory)	\$ 281,947	\$ 280,975	\$ 346,737	\$ 521,325	\$ 1,430,984	\$ 754
Actual Offsetting Collections (Discretionary and Mandatory)	(13)	(10)	(763)	(22,474)	(23,260)	(350)
Outlays, Net (Discretionary and Mandatory)	281,934	280,965	345,974	498,851	1,407,724	404
Distributed Offsetting Receipts	(29,813)	(349,381)	-	(993)	(380,187)	-
<b>Agency Outlays, Net (Discretionary and Mandatory)</b>	<b>\$ 252,121</b>	<b>\$ (68,416)</b>	<b>\$ 345,974</b>	<b>\$ 497,858</b>	<b>\$ 1,027,537</b>	<b>\$ 404</b>

**Summary of Other Agency Budgetary Accounts**

	<u>Budgetary Resources</u>	<u>Status of Budgetary Resources</u>	<u>Net Outlays</u>
ACF	\$ 54,176	\$ 54,176	\$ 49,542
ACL	1,936	1,936	1,680
AHRQ	400	400	174
CDC	14,319	14,319	10,800
CMS	459,411	459,411	383,999
FDA	5,590	5,590	2,331
HRSA	11,189	11,189	9,126
IHS	7,251	7,251	4,532
NIH	34,681	34,681	29,233
OS	6,167	6,167	2,810
PSC	1,958	1,958	488
SAMHSA	3,795	3,795	3,143
<b>Totals</b>	<b>\$ 600,873</b>	<b>\$ 600,873</b>	<b>\$ 497,858</b>

[1] "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of \$3.9 billion and net outlays of \$3.8 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.



### Deferred Maintenance and Repairs

For the Years Ended September 30, 2015 and 2014

The Federal Accounting Standards Advisory Board (FASAB) issued SFFAS No. 42, *Deferred Maintenance and Repairs*: Amending Statement of Federal Financial Accounting Standards 6, 14, 29, and 32 effective for periods after September 30, 2014. This standard clarifies that repair activities should be included to better reflect asset management practices, and improve reporting on deferred maintenance and repairs. Deferred maintenance and repairs are maintenance and repairs activities not performed when they should have been or were scheduled to be, and then put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components, and other activities needed to preserve the asset so that it continues to provide acceptable service, meets applicable building codes, and achieves its expected life. Maintenance and repairs do not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance and repair expenses are recognized as incurred. CDC, NIH, and FDA all use the condition assessment survey for all classes of property. IHS uses two methods to assess installations – annual general inspections and facility condition surveys. Deferred maintenance and repairs have been reported for all active and inactive assets; excess buildings and structures that are slated for disposal or demolition are not included. For buildings, equipment, and other structures, acceptable condition is defined in accordance with standards comparable to those used in private industry. For example, factors can include PP&E location, age, design etc. Prior year numbers have been adjusted to conform to SFFAS No. 42 and the current year presentation.

Category of Asset	Estimated Cost to Return to Acceptable Condition (in Millions)	
	2015	2014
General PP&E		
Buildings	\$ 2,216	\$ 1,773
Equipment	13	12
Other Structures	21	11
Total	<u>\$ 2,250</u>	<u>\$ 1,796</u>

## Social Insurance

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for five decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is presented in accordance with the requirements of the FASAB. Included are descriptions of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The basis for the projections has changed since last year due to the enactment of the MACRA. This law repealed the SGR formula that set physician fee schedule payments, which were usually modified. In the 2014 report, the income, expenditures, and assets for Part B reflected the *projected baseline* scenario, which assumed an override of the SGR payment provisions and an increase in the physician fee schedule equal to the average of the most recent 10 years of SGR overrides (through March 2015) or 0.6 percent. Since the new legislation replaced the SGR system with specified payment updates for physicians, the projections in this year's report are based on current law.

While the physician payment updates and new incentives put in place by MACRA avoid the significant short-range physician payment issues that would have resulted from the SGR system approach, they nevertheless raise important long-range concerns. In particular, additional payments of \$500 million per year for one group of physicians and 5 percent annual bonuses for another group are scheduled to expire in 2025, resulting in a significant one-time payment reduction for most physicians. In addition, the law specifies the physician payment update amounts for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The Trustees anticipate that physician payment rates under current law will be lower than they would have been under the SGR formula by 2048 and will continue to worsen thereafter. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term under current law.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012*; the *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; and the *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2023, by 2.9 percent from April 1, 2023 through September 30, 2023, by 1.1 percent from October 1, 2023 through March 31, 2024, and by 4 percent from April 1, 2024 through September 30, 2024. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2024.

These projections also incorporate the effects of the Patient Protection and *Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*. This legislation, referred to collectively as the *Affordable Care Act*, contained roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving benefits, combating fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the *Affordable Care Act* and MACRA that lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. It is conceivable that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range; however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. The current-law cost projections reflect the physicians' payment levels expected under the MACRA payment rules and the *Affordable Care Act*-mandated reductions in other Medicare payment rates. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes legislative changes that result in: (i) physician payment updates that transition from the update specified in current law for 2024 to the rate of growth in the Medicare Economic Index of 2.3 percent for 2039 and later; (ii) a partial phase-out of the *Affordable Care Act* reductions in Medicare payment rates; and (iii) an elimination of the cost-saving actions of the Independent Payment Advisory Board (IPAB). The difference between the illustrative alternative and the current-law projections demonstrates that the long-range costs could be substantially higher than shown throughout much of the report if the MACRA<sup>8</sup> and *Affordable Care Act*<sup>9</sup> cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 25 in these financial statements, in appendix V.C of this year's annual Medicare Trustees Report, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from [www.cms.hhs.gov/ReportsTrustFunds](http://www.cms.hhs.gov/ReportsTrustFunds).<sup>10</sup>

<sup>8</sup> Under MACRA, a significant one-time payment reduction is scheduled for most physicians in 2025. In addition, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.3 percent per year in the long range.

<sup>9</sup> Under the *Affordable Care Act*, Medicare's annual payment rate updates for most categories of providers would be reduced below the increase in providers' input prices by the growth in economy-wide private nonfarm business multifactor productivity (1.1 percent over the long range). In addition, the IPAB would be charged with recommending cost savings as are necessary to hold overall per capita Medicare growth to the average of the Consumer Price Index (CPI-U) and CPI-medical increases in 2015-2019 and to the rate of per capita GDP growth plus 1 percentage point thereafter (subject to certain limits). Unless overridden by lawmakers, these recommendations would be implemented automatically.

<sup>10</sup> The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

## Actuarial Projections

### Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is based on statutory price updates and volume and intensity growth derived from the “factors contributing to growth” model, which decomposes the major drivers of historical and projected health spending growth into distinct factors. The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection. The Trustees’ methodology is consistent with Finding III-2 and Recommendation III-2 of the 2010-2011 Medicare Technical Review Panel<sup>11</sup> and incorporates refinements and improvements based on research conducted by the CMS Office of the Actuary.

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the longstanding GDP plus 1 percent assumption while incorporating several key refinements (Recommendation III-1).<sup>12</sup> Specifically, the Panel recommended two separate means of establishing long-range growth rates:

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the *Affordable Care Act*) compared to private health insurance and other payers of health care in the U.S. This refinement results in an increase in the long-range pre-*Affordable Care Act* baseline cost growth assumption for Medicare to GDP plus 1.4 percent.
- The “factors contributing to growth” model approach builds upon the key considerations underlying the earlier GDP plus 1 percent assumption. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.<sup>13</sup> It benefits from additional information that was not available when the 2000 Technical Panel recommended the GDP plus 1 percent assumption.

The Trustees (i) used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period and (ii) checked the ultimate Medicare cost growth assumptions derived from this approach for reasonableness by comparing them to results produced by an average “GDP plus” approach.

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010-2011 Technical Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

Prior to the *Affordable Care Act*, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers’ input prices for the market basket of employee wages and benefits,

<sup>11</sup> The Panel’s final report is available at [www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TechnicalPanelReport2010-2011.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TechnicalPanelReport2010-2011.pdf).

<sup>12</sup> For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate. Similarly, these growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

<sup>13</sup> Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. “Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?” *Health Affairs*, 28, no. 5 (2009): 1276-1284.

facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the *Affordable Care Act* were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall.<sup>14</sup> The *Affordable Care Act* requires that many of these Medicare payment updates be reduced by the 10-year moving average increase in economy-wide private nonfarm business multifactor productivity,<sup>15</sup> which the Trustees assume will be 1.1 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of health care providers:

**(i) All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.**

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year per capita increases for these provider services start at 4.0 percent in 2039, or GDP plus 0.0 percent, declining gradually to 3.6 percent in 2089, or GDP minus 0.3 percent.

**(ii) Physician services**

Payment rate updates are 0.75 percent per year under the assumption that all physicians would be participating in alternative payment models (APMs). The year-by-year per capita growth rates for physician payments are assumed to be 3.3 percent in 2039, or GDP minus 0.7 percent, declining to 2.8 percent in 2089, or GDP minus 1.1 percent.

**(iii) Certain SMI Part B services that are updated annually by the CPI increase less the increase in economy-wide productivity.**

Such services include durable medical equipment,<sup>16</sup> care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.3 percent in 2039, or GDP minus 0.7 percent, declining to 2.8 percent in 2089, or GDP minus 1.1 percent.

**(iv) All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services.**

These Part B outlays constitute an estimated 15 percent of total Part B expenditures in 2024 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.<sup>17</sup> The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year per capita growth rates for these services are 4.9 percent in 2039, or GDP plus 0.9 percent, declining to 4.4 percent by 2089, or GDP plus 0.5 percent.

<sup>14</sup> Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices. Prior to the *Affordable Care Act*, the law did not specify any such adjustments after 2009.

<sup>15</sup> For convenience the term *economy-wide private nonfarm business multifactor productivity* will henceforth be referred to as *economy-wide productivity*.

<sup>16</sup> Certain durable medical equipment (DME) is subject to competitive bidding, and the price is assumed to grow by the CPI increase less the increase in economy-wide productivity, the same update specified for DME not subject to bidding.

<sup>17</sup> For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

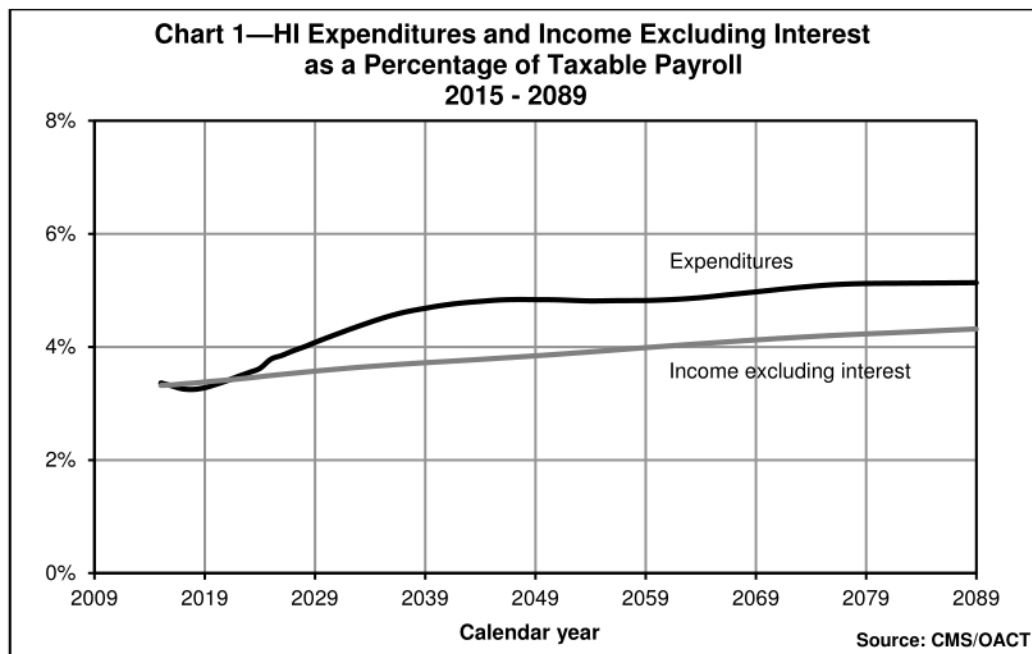
In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the three long-range assumptions, the weighted average growth rate for Part B is 3.8 percent per year for the last 50 years of the projection period, or GDP minus 0.2 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 4.0 percent over this same time period or GDP minus 0.0 percent, while the growth rate in 2089 is 3.7 percent or GDP minus 0.2 percent.

### HI Cash Flow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll).

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates shown in the 2015 report are lower than those from the 2014 report for all years in the long range, primarily due to modified income-technology and price elasticity assumptions.



Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income, as a percentage of taxable payroll, is estimated to remain constant at 2.90 percent. In addition, high-income workers pay an additional 0.9 percent of their earnings above \$200,000 (for single workers) or \$250,000 (for married couples filing joint income tax returns) in 2013 and later. Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to

such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

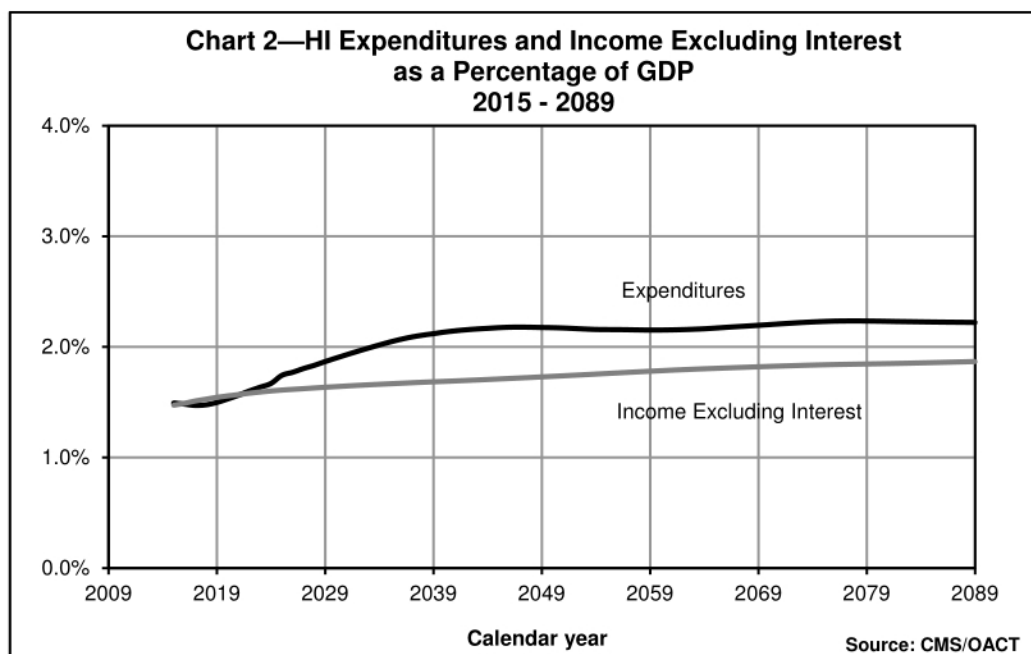
As indicated in Chart 1, the cost rate is projected to decline through 2018, largely due to: (i) expenditure growth that was constrained in part by the sequester and low payment updates; and (ii) a rebound of taxable payroll growth from recession levels. After 2018, the cost rate is projected to rise primarily due to retirements of those in the baby boom generation and partly due to a projected return to modest health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 1.0 percent through 2024 and 1.1 percent thereafter. Under the illustrative alternative scenario, if the slower price updates were not feasible in the long range and were phased down during 2020-2034, then the HI cost rate would be 4.8 percent in 2035 and 8.1 percent in 2085. These levels are about 7 percent and 58 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

### HI and SMI Cash Flow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the U.S. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

#### HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2014, the expenditures were \$269.3 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.6 percent in 2089.

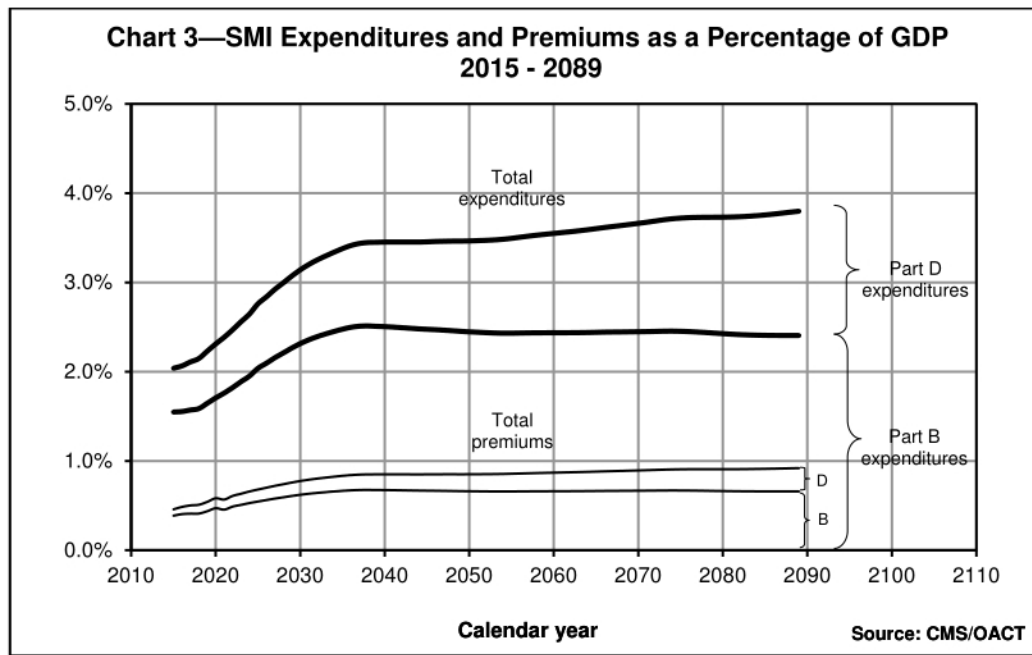


### SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and federal general revenue payments.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.

In 2014, SMI expenditures were \$344.0 billion, or about 2.0 percent of GDP. Under current law, they would grow to about 3.5 percent of GDP within 25 years and to 3.8 percent by the end of the projection period. (Under the illustrative alternative, total SMI expenditures in 2089 would be 5.4 percent of GDP.)



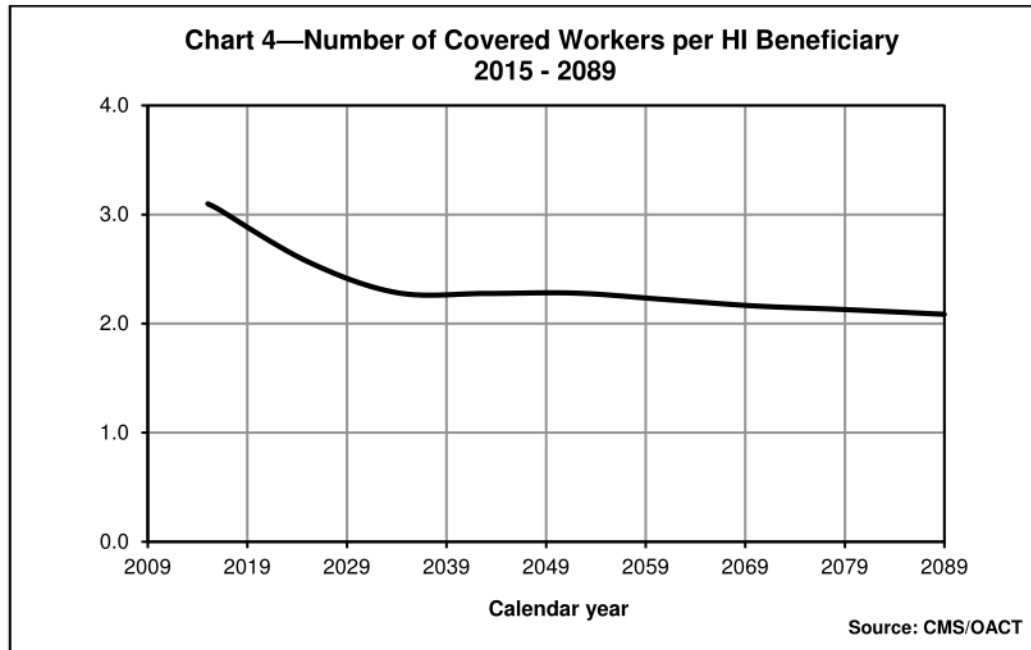
To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2015 by about 4.3 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special state payments to the Part D account are set by law at a declining portion of the states' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the state payments are also expected to increase faster than GDP.



## Worker-to-Beneficiary Ratio

### HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation. In 2014, every beneficiary had 3.2 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2089.



## Sensitivity Analysis

To prepare projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.<sup>18</sup> The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.<sup>19</sup>

<sup>18</sup> Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.

<sup>19</sup> The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

For this analysis, the intermediate economic and demographic assumptions in the *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2015 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values initially increase, as the effects of the *Affordable Care Act* result in trust fund surpluses, and then decrease through the first 25 to 30 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process used for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

### Health Care Cost Factors

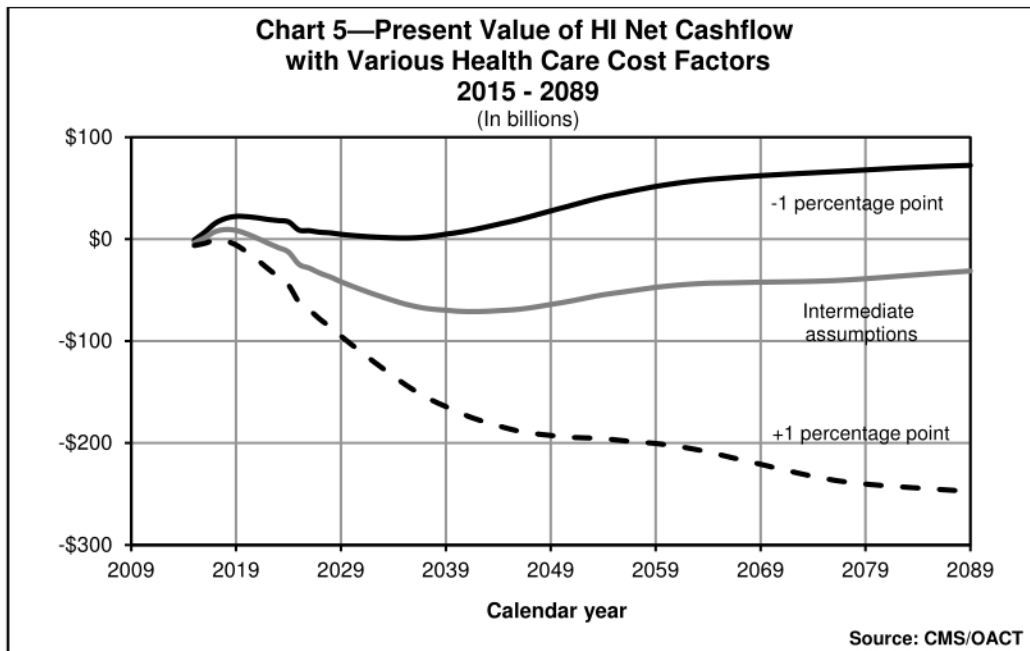
Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as assumed for the intermediate assumptions.

**Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions**

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	\$2,743	-\$3,187	-\$12,594

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by \$5,930 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by \$9,407 billion.

Chart 5 shows projections of the present value of the estimated net cash flow under the three alternative annual growth rate assumptions presented in Table 1.



This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI trust fund as a result of the *Affordable Care Act*. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

### Real-Wage Differential

Table 2 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.<sup>20</sup> In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.3, 3.9, and 4.5 percent, respectively.

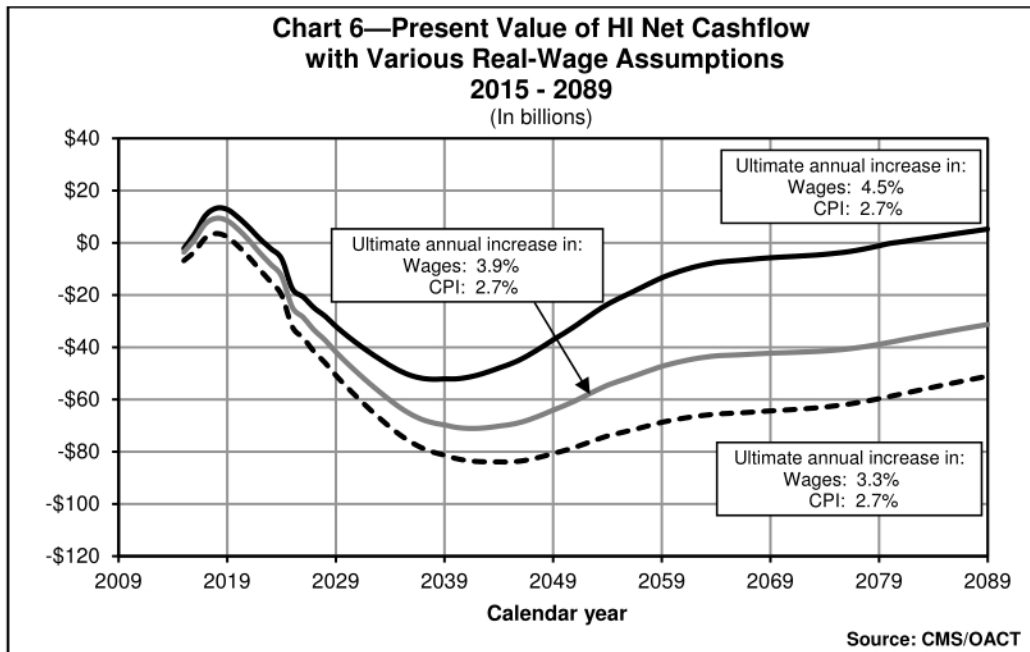
**Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions**

Ultimate percentage increase in wages – CPI	3.3 – 2.7	3.9 – 2.7	4.5 – 2.7
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures (in billions)	–\$4,365	–\$3,187	–\$1,326

<sup>20</sup> The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately \$1,550 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about \$980 billion.

Chart 6 shows projections of the present value of the estimated net cash flow under the three alternative real-wage differential assumptions presented in Table 2.



As illustrated in Chart 6, faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the *Affordable Care Act* and MACRA depends critically on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. There is a strong possibility that certain payment changes will not be viable in the long range.

## Consumer Price Index

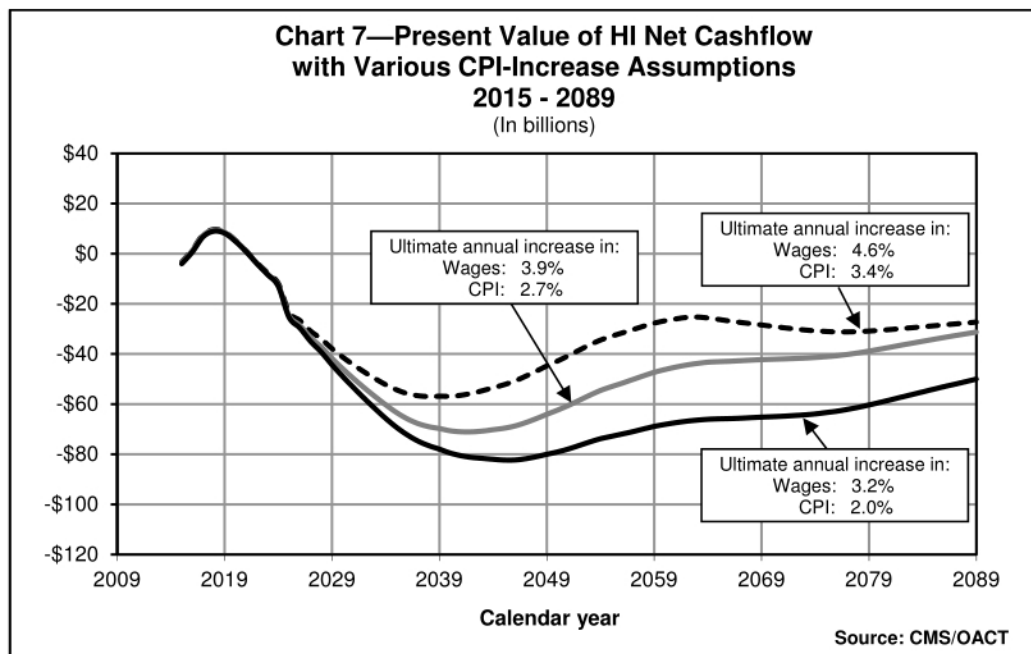
**Table 3—Present Value of Estimated HI Income  
Less Expenditures under Various CPI-Increase Assumptions**

Ultimate percentage increase in wages – CPI	4.6 – 3.4	3.9 – 2.7	3.2 – 2.0
Income minus expenditures (in billions)	–\$2,386	–\$3,187	–\$4,221

Table 3 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.4, 2.7, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.2 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.6, 3.9, and 3.2 percent, respectively.

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.4 percent, the deficit decreases by \$801 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by \$1,034 billion.

Chart 7 shows projections of the present value of net cash flow under the three alternative CPI rate-of-increase assumptions presented in Table 3.



As Chart 7 indicates, this assumption has a small impact when the cash flow is expressed as present values. The relative insensitivity of the projected present values of HI cash flow to different levels of general inflation occurs because inflation tends to proportionately affect both income and costs in a similar manner. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9 percent HI tax rate required by the *Affordable Care Act* for workers with earnings above \$200,000 or \$250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

### Real-Interest Rate

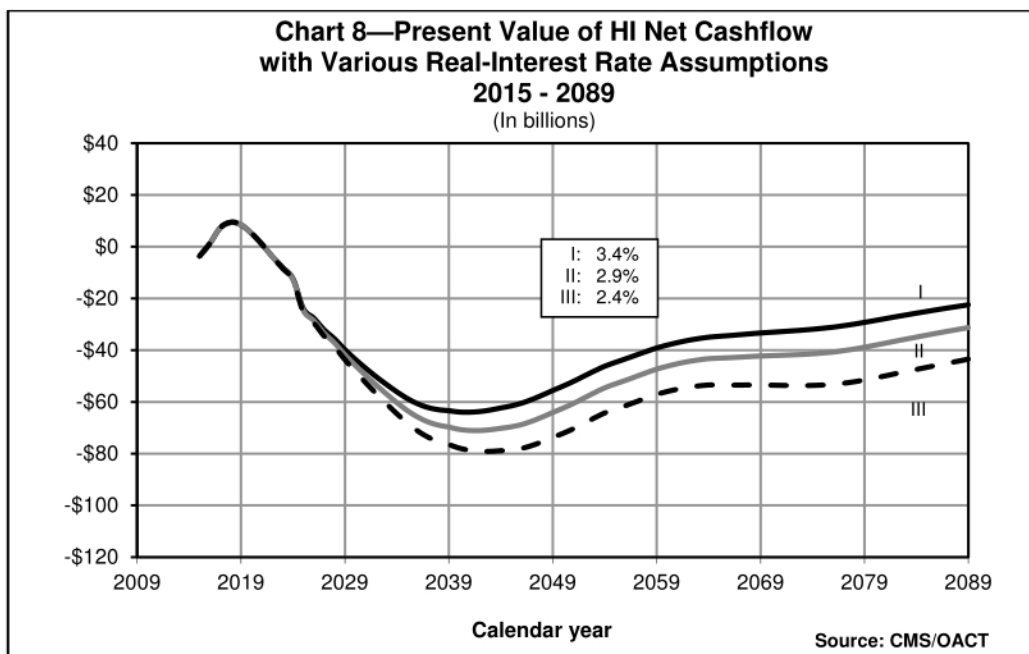
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.4, 2.9, and 3.4 percent. In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, which results in ultimate annual yields of 5.1, 5.6, and 6.1 percent, respectively.

**Table 4—Present Value of Estimated HI Income  
Less Expenditures under Various Real-Interest Assumptions**

Ultimate real-interest rate	2.4 percent	2.9 percent	3.4 percent
Income minus expenditures (in billions)	-\$3,774	-\$3,187	-\$2,704

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately \$105 billion.

Chart 8 shows projections of the present value of the estimated net cash flow under the three alternative real-interest assumptions presented in Table 4.



As shown in Chart 8, the projected HI cash flow, when expressed in present values, is fairly sensitive to the interest assumption. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2030. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

## Fertility Rate

Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.8, 2.0, and 2.2 children per woman.

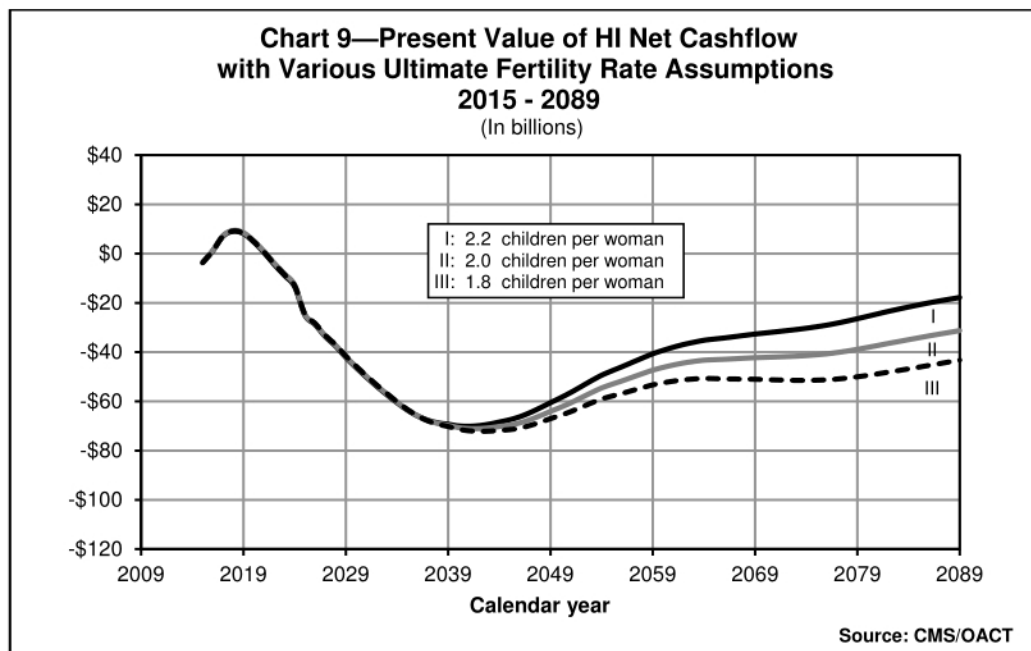
**Table 5—Present Value of Estimated HI Income  
Less Expenditures under Various Fertility Rate Assumptions**

Ultimate fertility rate <sup>1</sup>	1.8	2.0	2.2
Income minus expenditures (in billions)	-\$3,547	-\$3,187	-\$2,793

<sup>1</sup>The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As Table 5 demonstrates, for an increase of 0.2 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately \$375 billion.

Chart 9 shows projections of the present value of the net cash flow under the three alternative fertility rate assumptions presented in Table 5.



As Chart 9 indicates, the fertility rate assumption has a substantial impact on projected HI cash flows. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. On the other hand, under the lower fertility rate assumptions, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

## Net Immigration

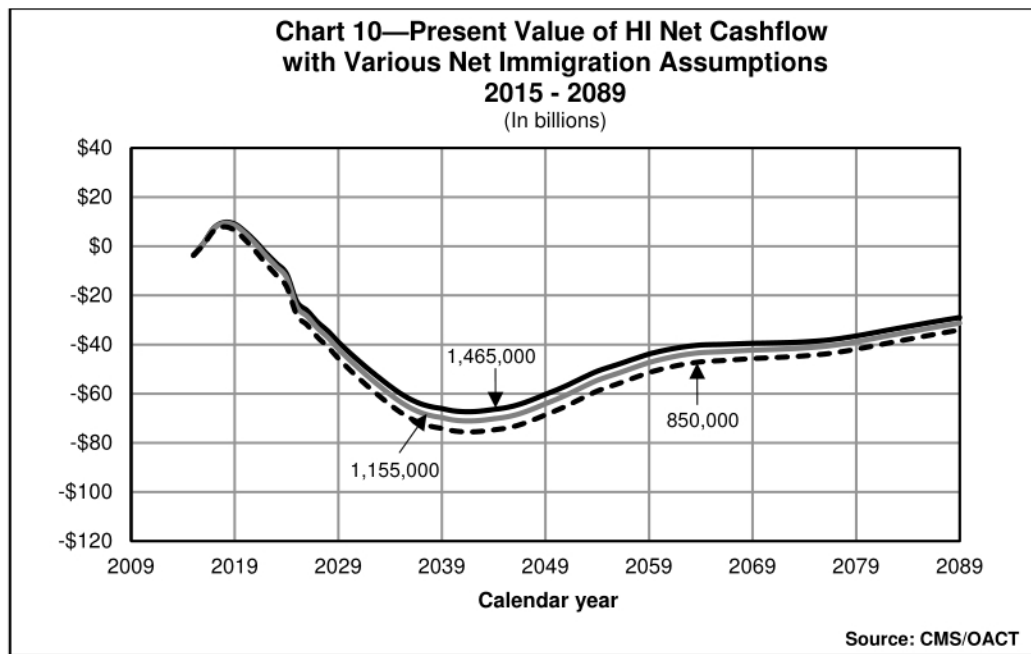
Table 6 shows the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 850,000 persons, 1,155,000 persons, and 1,465,000 persons per year.

**Table 6—Present Value of Estimated HI Income  
Less Expenditures under Various Net Immigration Assumptions**

Average annual net immigration	850,000	1,155,000	1,465,000
Income minus expenditures (in billions)	-\$3,455	-\$3,187	-\$2,981

As indicated in Table 6, if the average annual net immigration assumption is 850,000 persons, the deficit—expressed in present-value dollars—increases by \$268 billion. Conversely, if the assumption is 1,465,000 persons, the deficit decreases by \$206 billion.

Chart 10 shows projections of the present value of net cash flow under the three alternative average annual net immigration assumptions presented in Table 6.



Higher net immigration results in smaller HI cash flow deficits, as illustrated in Chart 10. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.



## Trust Fund Finances and Sustainability

### HI

The short-range financial outlook for the HI trust fund is about the same as projected in last year's annual report, as factors causing improved finances are offset by other changes. Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI trust fund is 2030, the same as in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI tax income in 2014 was somewhat higher than last year's estimate, mostly due to adjustments for prior years,<sup>21</sup> but is projected to be slightly lower through 2019; after 2019, however, projections of earnings throughout the period are higher mostly due to assumptions of slower projected growth in employer-sponsored health insurance—a factor that increases wages. Although HI expenditures in 2014 were nearly equal to the previous estimate, projected expenditures are higher at the end of the 10-year period than shown in last year's report, largely due to increases in provider payment update assumptions that reflect recent trends.

HI expenditures have exceeded income annually since 2008. However, the Trustees project slight surpluses in 2015 through 2023, with a return to deficits thereafter until the trust fund becomes depleted in 2030. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policy makers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

### SMI

The SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no provision in the law for transferring assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2015 is adequate to cover 2015 expected expenditures but would need to be increased in future years in order to restore the financial status of the Part B account to a satisfactory level.<sup>22</sup> Similarly, Part D income and outgo would remain in balance as a result of the annual adjustment of premium and general revenue income to cover costs. The appropriation for Part D general revenues has generally been set such that amounts can be transferred to the Part D account on an as-needed basis.

The Part B and Part D accounts in the SMI trust fund are adequately financed because premium and general revenue income are reset each year to cover expected costs. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

<sup>21</sup> Initial appropriations of payroll taxes are made on an estimated basis, and then each year adjustments are made to the appropriations for prior years to reflect actual tax receipts.

<sup>22</sup> In 2016, a hold-harmless provision that restricts Part B premium increases for most beneficiaries is expected to cause a substantial increase in the Part B premium rate for other beneficiaries.

## Medicare Overall

The *Medicare Modernization Act* requires the Board of Trustees to determine whether the difference between Medicare outlays and dedicated financing sources<sup>23</sup> is projected to exceed 45 percent of total Medicare outlays under current law within the next seven fiscal years (2015-2021). If this level is attained within the seven year timeframe, federal law requires a determination of projected excess general revenue Medicare funding. For the 2015 Medicare Trustees Report, this difference is not expected to exceed 45 percent of total expenditures in fiscal years 2015-2021 (the first seven years of the projection), and therefore the Trustees are not issuing this determination.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then these further policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2015 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of such reforms should not be delayed."

<sup>23</sup>Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

## Other Information



*About the photo*

*Secretary Burwell speaking at the 50th Medicare and Medicaid Anniversary celebration at the HHS Headquarters.*

### In This Section

- Other Financial Information
- Improper Payments Information Act Report
- Summary of Financial Statement Audit and Management Assurances
- FY 2015 Top Management and Performance Challenges Identified by the OIG
- Department's Response to OIG Top Management Challenges

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## OTHER FINANCIAL INFORMATION

## Combined Schedule of Spending By Object Class

As of September 30, 2015

(in Millions)

The Combined Schedule of Spending presented below includes HHS's spending for all programs with spending greater than \$1 billion to increase transparency.

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Financial Assistance Direct Payments	Other Contractual Services	Personnel Compensation & Benefits	Other	FY 2015
Medicaid	\$ 375,142	\$ -	\$ 101	\$ 17	\$ 3,637	\$ 378,897
Medicare Hospital Insurance	-	277,001	2	-	8,071	285,074
Medicare Supplementary Medical Insurance	-	276,841	44	-	4,755	281,640
Payments to Trust Funds	195,385	72	-	-	67,445	262,902
Medicare Prescription Drug Benefit (Medicare Part D)	-	80,429	-	-	154	80,583
Taxation on OASDI Benefits, HI	20,208	-	-	-	-	20,208
Temporary Assistance for Needy Families	16,657	-	58	2	-	16,717
State Children's Health Insurance Program	11,486	-	4	-	6	11,496
Children and Families Services	10,121	-	262	143	19	10,545
Transitional Reinsurance Program	-	8,249	-	-	-	8,249
Foster Care and Permanency	7,360	-	26	-	1	7,387
Indian Health Services	2,834	-	803	1,332	733	5,702
National Cancer Institute	3,609	-	1,178	504	95	5,386
Primary Health Care	4,794	-	233	70	15	5,112
Allergy and Infectious Diseases	3,043	-	1,492	310	83	4,928
Child Support Enforcement and Family Support	3,637	-	710	-	-	4,347
Medicare Health Information Technology Incentive	-	4,282	-	-	-	4,282
Low Income Home Energy Assistance	3,392	-	3	-	-	3,395
Heart, Lung, and Blood Institute	2,237	-	551	152	33	2,973
Child Care Entitlement to States	2,929	-	17	-	-	2,946
Mental Health	1,982	-	348	97	20	2,447
Child Care and Development Block Grant	2,396	-	39	-	-	2,435
Ryan White HIV/AIDS Program	2,199	-	83	27	9	2,318
General Medical Sciences	2,141	-	103	29	2	2,275
Substance Abuse Treatment	2,024	-	146	10	7	2,187
Risk Adjustment Program Payment	-	2,141	-	-	-	2,141
Public Health and Social Services	455	-	1,085	119	304	1,963
Aging Services Programs	1,850	-	35	27	4	1,916
Health Care Fraud and Abuse	-	-	1,775	55	7	1,837
Diabetes and Digestive and Kidney Diseases	1,417	-	206	112	23	1,758
Social Services Block Grant	1,648	-	11	1	-	1,660
Service and Supply Fund	-	-	980	261	372	1,613
Neurological Disorders and Stroke	1,205	-	207	85	22	1,519
Refugee and Entrant Assistance	1,247	-	137	10	4	1,398
Child Health and Human Development	961	-	313	98	20	1,392
Medicare and Medicaid Innovation	595	63	649	61	3	1,371
Public Health Preparedness and Response	633	-	273	104	343	1,353
National Institute on Aging	1,094	-	151	68	16	1,329
HHS Service and Supply Fund	-	-	974	150	98	1,222
Disease Control Research and Training	605	-	332	151	115	1,203
Chronic Disease Prevention and Health Promotion	764	-	301	128	8	1,201
HIV/AIDS, Viral Hepatitis, STD and Tuberculosis Prevention	751	-	185	166	16	1,118
National Institute on Drug Abuse	723	-	222	66	13	1,024
Other Agency Budgetary Accounts	11,589	3,172	12,450	6,449	2,372	36,032
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 699,113</b>	<b>\$ 652,250</b>	<b>\$ 26,489</b>	<b>\$ 10,804</b>	<b>\$ 88,825</b>	<b>\$ 1,477,481</b>

### Combined Schedule of Spending By Object Class

As of September 30, 2014

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Financial Assistance Direct Payments	Other Contractual Services	Personnel Compensation & Benefits	Other	FY 2014
Medicaid	\$ 325,548	\$ -	\$ 96	\$ 17	\$ 3,359	\$ 329,020
Medicare Hospital Insurance	-	272,336	5	-	6,630	278,971
Medicare Supplementary Medical Insurance	-	258,024	53	-	5,982	264,059
Payments to Trust Funds	225,295	-	-	-	33,431	258,726
Medicare Prescription Drug Benefit (Medicare Part D)	-	71,581	-	-	-	71,581
Taxation on OASDI Benefits, HI	18,066	-	-	-	-	18,066
Temporary Assistance for Needy Families	16,702	-	55	2	-	16,759
State Children's Health Insurance Program	10,054	-	21	-	37	10,112
Children and Families Services	9,455	-	280	141	18	9,894
Transitional Reinsurance Program	-	-	-	-	-	-
Foster Care and Permanency	7,393	-	35	-	-	7,428
Indian Health Services	2,756	-	813	1,298	562	5,429
National Cancer Institute	2,981	-	1,424	492	100	4,997
Primary Health Care	3,652	-	199	68	10	3,929
Allergy and Infectious Diseases	2,744	-	1,336	302	75	4,457
Child Support Enforcement and Family Support	3,569	-	756	-	-	4,325
Medicare Health Information Technology Incentive	-	6,809	-	-	-	6,809
Low Income Home Energy Assistance	3,375	-	26	-	-	3,401
Heart, Lung, and Blood Institute	2,229	-	578	147	36	2,990
Child Care Entitlement to States	2,916	-	30	-	-	2,946
Mental Health	2,096	-	305	95	21	2,517
Child Care and Development Block Grant	2,336	-	35	-	(1)	2,370
Ryan White HIV/AIDS Program	2,192	-	97	24	2	2,315
General Medical Sciences	2,252	-	119	28	2	2,401
Substance Abuse Treatment	2,024	-	141	8	8	2,181
Risk Adjustment Program Payment	-	-	-	-	-	-
Public Health and Social Services	238	-	871	113	333	1,555
Aging Services Programs	1,663	-	32	21	3	1,719
Health Care Fraud and Abuse	-	-	1,546	51	4	1,601
Diabetes and Digestive and Kidney Diseases	1,512	-	255	108	27	1,902
Social Services Block Grant	1,647	-	10	1	-	1,658
Service and Supply Fund	7	-	966	247	344	1,564
Neurological Disorders and Stroke	1,298	-	201	84	21	1,604
Refugee and Entrant Assistance	1,411	-	109	6	2	1,528
Child Health and Human Development	892	-	302	96	24	1,314
Medicare and Medicaid Innovation	564	116	452	45	4	1,181
Public Health Preparedness and Response	627	-	272	105	398	1,402
National Institute on Aging	925	-	147	65	17	1,154
HHS Service and Supply Fund	-	-	825	151	66	1,042
Disease Control Research and Training	-	-	-	-	-	-
Chronic Disease Prevention and Health Promotion	764	-	289	124	8	1,185
HIV/AIDS, Viral Hepatitis, STD and Tuberculosis Prevention	741	-	193	165	18	1,117
National Institute on Drug Abuse	799	-	231	63	13	1,106
Other Agency Budgetary Accounts	11,746	290	15,176	6,264	2,587	36,063
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 672,469</b>	<b>\$ 609,156</b>	<b>\$ 28,281</b>	<b>\$ 10,331</b>	<b>\$ 54,141</b>	<b>\$ 1,374,378</b>

### Consolidating Balance Sheet by Budget Function

As of September 30, 2015

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
<b>Assets (Note 2)</b>							
<b>Intragovernmental Assets</b>							
Fund Balance with Treasury (Note 3)	\$ 9,925	\$ 151,312	\$ 44,785	\$ 13,437	\$ 219,459	\$ -	\$ 219,459
Investments, Net (Note 4)	-	5,658	263,993	-	269,651	-	269,651
Accounts Receivable, Net (Note 5)	92	2,632	85,026	3	87,753	(86,748)	1,005
Other Assets (Note 8)	16	192	24	15	247	(69)	178
<b>Total Intragovernmental Assets</b>	<b>10,033</b>	<b>159,794</b>	<b>393,828</b>	<b>13,455</b>	<b>577,110</b>	<b>(86,817)</b>	<b>490,293</b>
Accounts Receivable, Net (Note 5)	-	14,724	6,775	416	21,915	-	21,915
Inventory and Related Property, Net (Note 6)	-	9,516	-	-	9,516	-	9,516
General Property, Plant and Equipment, Net (Note 7)	-	5,609	308	-	5,917	-	5,917
Other Assets (Note 8)	-	1,151	3	-	1,154	-	1,154
<b>Total Assets</b>	<b>\$ 10,033</b>	<b>\$ 190,794</b>	<b>\$ 400,914</b>	<b>\$ 13,871</b>	<b>\$ 615,612</b>	<b>\$ (86,817)</b>	<b>\$ 528,795</b>
<b>Stewardship Land (Notes 1 and 20)</b>							
<b>Liabilities (Note 9)</b>							
<b>Intragovernmental Liabilities</b>							
Accounts Payable	\$ 21	\$ 260	\$ 86,757	\$ -	\$ 87,038	\$ (86,729)	\$ 309
Other Liabilities (Note 13)	2	3,272	9	414	3,697	(88)	3,609
<b>Total Intragovernmental Liabilities</b>	<b>23</b>	<b>3,532</b>	<b>86,766</b>	<b>414</b>	<b>90,735</b>	<b>(86,817)</b>	<b>3,918</b>
Accounts Payable	12	482	75	5	574	-	574
Entitlement Benefits Due and Payable (Note 10)	-	41,928	66,221	-	108,149	-	108,149
Accrued Liabilities (Note 12)	698	12,965	(63)	650	14,250	-	14,250
Federal Employee and Veterans Benefits (Note 11)	3	12,062	7	-	12,072	-	12,072
Contingencies and Commitments (Note 14)	-	9,095	10	-	9,105	-	9,105
Other Liabilities (Note 13)	19	2,258	1,035	8	3,320	-	3,320
<b>Total Liabilities</b>	<b>755</b>	<b>82,322</b>	<b>154,051</b>	<b>1,077</b>	<b>238,205</b>	<b>(86,817)</b>	<b>151,388</b>
<b>Net Position</b>							
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	-	(100)	30,284	-	30,184	-	30,184
Unexpended Appropriations - All Other funds	9,200	94,120	-	12,769	116,089	-	116,089
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	-	4,901	216,579	-	221,480	-	221,480
Cumulative Results of Operations - All Other funds	78	9,551	-	25	9,654	-	9,654
<b>Total Funds from Dedicated Collections</b>	<b>-</b>	<b>4,801</b>	<b>246,863</b>	<b>-</b>	<b>251,664</b>	<b>-</b>	<b>251,664</b>
<b>Total All Other Funds</b>	<b>9,278</b>	<b>103,671</b>	<b>-</b>	<b>12,794</b>	<b>125,743</b>	<b>-</b>	<b>125,743</b>
<b>Total Net Position</b>	<b>9,278</b>	<b>108,472</b>	<b>246,863</b>	<b>12,794</b>	<b>377,407</b>	<b>-</b>	<b>377,407</b>
<b>Total Liabilities and Net Position</b>	<b>\$ 10,033</b>	<b>\$ 190,794</b>	<b>\$ 400,914</b>	<b>\$ 13,871</b>	<b>\$ 615,612</b>	<b>\$ (86,817)</b>	<b>\$ 528,795</b>

**Consolidating Statement of Net Cost by Budget Function**

For the Year Ended September 30, 2015

(in Millions)

Responsibility Segments	Education, Training, & Social Services	Intra-HHS Eliminations				Agency Combined Totals	Intra-HHS Eliminations		Consolidated Totals
		Health	Medicare	Income Security			Cost (-)	Revenue	
ACF	\$ 12,312	\$ -	\$ -	\$ 37,999		\$ 50,311	\$ (57)	\$ 15	\$ 50,269
ACL	1,755	-	-	-		1,755	(9)	9	1,755
AHRQ	-	179	-	-		179	(18)	197	358
CDC	-	10,246	-	-		10,246	(126)	223	10,343
CMS	-	366,691	547,135	-		913,826	(521)	15	913,320
FDA	-	3,189	-	-		3,189	(269)	12	2,932
HRSA	-	9,207	-	-		9,207	(138)	51	9,120
IHS	-	4,871	-	-		4,871	(160)	196	4,907
NIH	-	29,724	-	-		29,724	(617)	229	29,336
OS	-	2,949	-	-		2,949	(574)	719	3,094
PSC	-	684	-	-		684	(21)	542	1,205
SAMHSA	-	3,292	-	-		3,292	(38)	136	3,390
<b>Net Cost of Operations</b>	<b>\$ 14,067</b>	<b>\$ 431,032</b>	<b>\$ 547,135</b>	<b>\$ 37,999</b>		<b>\$ 1,030,233</b>	<b>\$ (2,548)</b>	<b>\$ 2,344</b>	<b>\$ 1,030,029</b>

**Gross Cost and Exchange Revenue**

For the Year Ended September 30, 2015

(in Millions)

Responsibility Segments	Intragovernmental						With the Public		
	Gross Cost			Less: Exchange Revenue			Gross Cost	Less: Exchange Revenue	Consolidated Net Cost of Operations
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated			
ACF	\$ 122	\$ (57)	\$ 65	\$ (31)	\$ 15	\$ (16)	\$ 50,235	\$ (15)	\$ 50,269
ACL	20	(9)	11	(9)	9	-	1,744	-	1,755
AHRQ	53	(18)	35	(197)	197	-	324	(1)	358
CDC	807	(126)	681	(367)	223	(144)	9,836	(30)	10,343
CMS	1,407	(521)	886	(27)	15	(12)	1,010,464	(98,018)	913,320
FDA	1,250	(269)	981	(33)	12	(21)	3,244	(1,272)	2,932
HRSA	253	(138)	115	(51)	51	-	9,043	(38)	9,120
IHS	815	(160)	655	(207)	196	(11)	5,503	(1,240)	4,907
NIH	1,604	(617)	987	(314)	229	(85)	28,998	(564)	29,336
OS	936	(574)	362	(777)	719	(58)	2,812	(22)	3,094
PSC	317	(21)	296	(1,019)	542	(477)	1,659	(273)	1,205
SAMHSA	101	(38)	63	(136)	136	-	3,328	(1)	3,390
Totals	\$ 7,685	\$ (2,548)	\$ 5,137	\$ (3,168)	\$ 2,344	\$ (824)	\$ 1,127,190	\$ (101,474)	\$ 1,030,029



### Freeze the Footprint

For the Year Ended September 30, 2015

Freeze the Footprint Baseline Comparison (in Square Footage)			
	2012 Baseline	2014 Year End	+/- Change
Total Leased	13,603,974	13,593,265	(10,709)
Total Owned	6,112,229	6,457,747	345,518
<b>Total</b>	<b>19,716,203</b>	<b>20,051,012</b>	<b>334,809</b>

Reporting of O&M Costs - Owned and Direct Lease Buildings (in Millions)			
	2012 Baseline	2014 Year End	+/- Change
Operation and Maintenance Costs	\$ 83.3	\$ 84.7	\$ 1.4

Consistent with Section 3 of the OMB Memorandum - 12-12, *Promoting Efficient Spending to Support Agency Operations* and OMB Management Procedures Memorandum 2013-02, the "Freeze the Footprint" policy implementing guidance, all *Chief Financial Officers Act of 1990* departments and agencies shall not increase the total square footage of their domestic office and warehouse inventory compared to the FY 2012 baseline. Compared to the FY 2012 Baseline, the HHS inventory of office and warehouse space increased by 334,809 square feet in FY 2014, an overall increase of 1.7%. This is consistent with our projections in the September 2014 HHS Freeze the Footprint Plan. Because of known projects currently underway, HHS continues to project that it will be the end of FY 2016 when we can meet the FY 2012 Baseline. HHS will accomplish this through aggressively pursuing space and cost savings in office and warehouse space, through implementation of the HHS 170 useable square feet per person utilization rate policy for office space and through targeted consolidation projects for both office and warehouse space.

## IMPROPER PAYMENTS INFORMATION ACT REPORT

### 1.0 Overview

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The United States Department of Health and Human Services (HHS or the Department) *FY 2015 Improper Payments Information Act* Report includes a discussion of the following information, as required by the *Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA); OMB Circular A-136; and Appendix C of OMB Circular A-123:

- Program Descriptions (Section 1.0)
- Risk Assessments (Section 2.0)
  - *Affordable Care Act* Risk Assessment (Section 2.10)
- Statistical Sampling Process (Section 3.0)
  - Error Rate Presentation (Section 3.10)
- Corrective Action Plans (CAPs) (Section 4.0)
  - Corrective Actions for High-Priority Programs (Section 4.10)
- Accountability in Reducing and Recovering Improper Payments (Section 5.0)
- Information Systems and Other Infrastructure (Section 6.0)
- Mitigation Efforts Related to Statutory or Regulatory Barriers (Section 7.0)
- Progress and Achievements (Section 8.0)
  - FY 2015 Progress (Section 8.10)
  - FY 2015 Achievements (Section 8.20)
- Improper Payment Reduction Outlook (Section 9.0)
  - Accompanying Improper Payment Reporting for OMB-Determined Risk-Susceptible Programs Notes (Section 9.10)
  - Accompanying Improper Payment Reporting for Superstorm Sandy Programs Notes (Section 9.20)
- Improper Payment Root Cause Categories (Section 10.0)
- Program-Specific Reporting Information (Section 11.0)
  - Medicare Fee-for-Service (FFS) (Parts A and B) (Section 11.10)
  - Medicare Advantage (Part C) (Section 11.20)
  - Medicare Prescription Drug Benefit (Part D) (Section 11.30)
  - Medicaid (Section 11.40)
  - Children's Health Insurance Program (CHIP) (Section 11.50)
  - Temporary Assistance for Needy Families (TANF) (Section 11.60)
  - Foster Care (Section 11.70)
  - Child Care and Development Fund (CCDF) (Section 11.80)
- Internal Control Over Payments (Section 12.0)
- Recovery Auditing Reporting (Section 13.0)
- Do Not Pay Initiative (Section 14.0)
- Superstorm Sandy Reporting Information (Section 15.0)
  - Head Start (Section 15.10)
  - Social Services Block Grant (SSBG) (Section 15.20)
  - Family Violence Prevention and Services (FVPS) (Section 15.30)
  - Assistant Secretary for Preparedness and Response (ASPR) Research (Section 15.40)
  - Centers for Disease Control and Prevention (CDC) Research (Section 15.50)
  - Substance Abuse and Mental Health Services Administration (SAMHSA) (Section 15.60)
  - National Institutes of Health (NIH) Research (Section 15.70)

## 1.0 Program Descriptions

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The following is a brief description of the risk-susceptible programs discussed in this report.

### ***OMB-Determined Risk-Susceptible Programs:***

1. **Medicare FFS** - A federal health insurance program for people age 65 or older, people younger than age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease.
2. **Medicare Part C** - A federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan.
3. **Medicare Part D** - A federal prescription drug benefit program for Medicare beneficiaries.
4. **Medicaid** - A joint federal/state program, administered by the states, that provides health insurance to certain low income individuals.
5. **CHIP** - A joint federal/state program, administered by the states, that provides health insurance for qualifying children.
6. **TANF** - A joint federal/state program, administered by the states, that provides time-limited cash assistance as well as job preparation, work support, and other services to needy families with children to promote work, responsibility, and self-sufficiency.
7. **Foster Care** - A joint federal/state program, administered by the states, for children who need placement outside their homes in a foster family home or a child care facility.
8. **CCDF** - A joint federal/state program, administered by the states, that provides child care financial assistance to low income working families.

### ***Superstorm Sandy Risk-Susceptible Programs:***

9. **Head Start** - A federal program that provides comprehensive developmental services for America's low-income children from birth to five years of age, and their families.
10. **SSBG** - A joint federal/state program, administered by the states, which supports programs that allow communities to achieve or maintain economic self-sufficiency to prevent, reduce or eliminate dependency on social services.
11. **FVPS Act** - A federal funding stream dedicated to the prevention of domestic violence as well as support of emergency shelters and related assistance for victims of domestic violence and their children.
12. **ASPR Research** - A federal initiative to build a strong scientific research dataset and to support research that will aid in the response to, and recovery from, Superstorm Sandy.
13. **CDC Research** - A federal effort to improve and enhance the emergency preparedness system to protect life and property from disasters.
14. **SAMHSA** - A joint federal/state initiative to provide continued and enhanced mental health and substance abuse treatment to affected parties.
15. **NIH Research** - A federal initiative to restore investment in biomedical research and infrastructure that was severely damaged or destroyed by Superstorm Sandy.

## 2.0 Risk Assessments

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In addition to the programs deemed by OMB to be susceptible to significant improper payments and those required to be measured under the Superstorm Sandy *Disaster Relief Appropriations Act of 2003 (Disaster Relief Act)*, HHS also reviews other programs to determine if they are susceptible to significant improper payments. From FY 2012 through FY 2014, HHS's risk assessment approach to meet the improper payment risk assessment requirements under IPERIA, and OMB Circular A-123, Appendix C, was part of a larger, agency-wide program

integrity process. In late FY 2015, HHS incorporated the improper payment risk assessment requirements into a new, qualitative risk assessment tool. As a result, for FY 2015, HHS conducted risk assessments under both approaches.

Per OMB Circular A-123, Appendix C, Part I.A.9.b, the new risk assessment tool—or questionnaire—contains nine factors that shall be taken into account during a risk assessment, including:

1. Whether the program reviewed is new to the agency;
2. The complexity of the program reviewed, particularly with respect to determining correct payment amounts;
3. The volume of payments made annually;
4. Whether payments or payment eligibility decisions are made outside of the agency, for example, by a state or local government, or a regional federal office;
5. Recent major changes in program funding, authorities, practices, or procedures;
6. The level, experience, and quality of training for personnel responsible for making program eligibility determinations or certifying that payments are accurate;
7. Inherent risks of improper payments due to the nature of agency programs or operations;
8. Significant deficiencies in the audit reports of the agency including, but not limited to, HHS Inspector General or Government Accountability Office (GAO) audit report findings, or other relevant management findings that might hinder accurate payment certification; and
9. Results from prior improper payment work.

In addition to these risk factors, the improper payment risk assessment questionnaire includes information on specific risks identified by the program that may lead to improper payments, as well as controls that may help mitigate those risks. By examining both the required risk factors and additional internal control information, the new risk assessment tool provides a comprehensive review and analysis of selected programs' operations to determine if a risk exists and the nature and extent of the risks identified.

In FY 2015, HHS reviewed three programs under the previous integrated risk assessment approach: Administration for Community Living (ACL) State Plan Development for Mandatory Grant Programs; Indian Health Service (IHS) Special Diabetes Initiative; and the National Partnership for Action to End Health Disparities. HHS also reviewed nine programs under the new risk assessment approach: Adoption Assistance; Nutrition Services; Health Costs, Quality, and Outcomes; National Breast and Cervical Cancer Early Detection; Food and Drug Administration (FDA) Grants; Ryan White HIV/AIDS Part B; IHS Interagency Agreements; Internal and National Emergency Ebola Response and Preparedness; and Access to Recovery Grants. HHS determined that all of the programs reviewed under the two risk assessment approaches were not at-risk for significant improper payments. The Centers for Medicare & Medicaid Services (CMS) did not complete an improper payment risk assessment in FY 2015, but has instead begun working on a comprehensive improper payment risk assessment to evaluate health insurance marketplace and related programs created under the *Patient Protection and Affordable Care Act* (see *Section 2.10* for more information on the *Affordable Care Act* risk assessment).

HHS also reviewed OMB guidance and departmental activities related to the oversight of employee pay and charge cards to determine if existing activities could be leveraged to meet IPERIA's requirement to assess the risk in these two payment categories. After determining that some of these processes could be leveraged—particularly for employee pay—HHS began planning to conduct qualitative risk assessments of employee pay and charge cards at the Program Support Center (PSC) and the following Operating Divisions (OpDivs): FDA, IHS, NIH, and the CDC/Agency for Toxic Substances and Disease Registry (ATSDR) in FY 2016. HHS will review these OpDivs because they comprise the vast majority of charge card program expenses and cardholders. HHS will report the risk

susceptibility for improper payments related to employee pay and charge cards in the FY 2016 Agency Financial Report (AFR).

## 2.10 Affordable Care Act Risk Assessment

The Department of Health and Human Services (HHS) and the Department of the Treasury each have responsibilities for ensuring payment accuracy in programs created under the *Affordable Care Act*. Performing comprehensive risk assessments is critical to establishing an effective program for achieving payment accuracy in future years. In FY 2015, both Departments finalized plans for and began to perform comprehensive improper payment risk assessments to determine areas that might affect Advance Premium Tax Credit (APTC), Premium Tax Credit (PTC), Cost-sharing Reduction and Basic Health Plan payment accuracy. Both Departments are leveraging the same Federally Funded Research and Development Center (FFRDC) to assist with conducting these risk assessments, which will facilitate interagency coordination and provide a comprehensive assessment of risk that takes into account activities by the Marketplaces, HHS, and the Internal Revenue Service. An update on the status and preliminary results of the FFRDC supported risk assessments will be reported in the FY 2016 AFR. In addition, both Departments have established internal controls to provide for effective program operations, reliable financial reporting, and compliance with laws and regulations.

## 3.0 Statistical Sampling Process

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Each program's statistical sampling process is discussed in *Section 11.0: Program-Specific Reporting Information* or *Section 15.0: Superstorm Sandy Reporting Information*. Unless otherwise stated in *Section 11.0* or *Section 15.0*, all programs that reported an error rate estimate complied with the requirement that all estimates be based on the equivalent of a statistically valid random sample of sufficient size to yield an estimate with a 90 percent confidence interval of plus or minus 2.5 percentage points around the estimate of the percentage of erroneous payments. In addition, seven of the eight programs that OMB determined are susceptible to significant improper payments are reporting error estimates calculated by a statistical contractor.

### 3.10 Error Rate Presentation

OMB Circular A-136 allows agencies to report net error rates in addition to the required gross error rates. Tables 1A and 1B in *Section 9.0: Improper Payment Reduction Outlook* present each at-risk or Superstorm Sandy program's gross and net error rates.

The *gross error rate* is the official program error rate; it is calculated by adding the sample's overpayments and underpayments and dividing by the total dollar value of the sample. The *net error rate* reflects the overall estimated monetary loss to the program; it is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample.

## 4.0 Corrective Action Plans (CAPs)

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Each program's CAP for reducing the estimated rate of improper payments can be found in *Section 11.0: Program-Specific Reporting Information* or *Section 15.0: Superstorm Sandy Reporting Information*. CAPs are used to set aggressive, realistic targets and outline a timetable to achieve scheduled targets. OMB approves all out-year error rate targets. The Department reviews CAPs annually to ensure plans focus on the root causes of the errors, thus making it more likely that targets are met. If targets are not met, HHS will develop new strategies, adjust staffing and other resources, and possibly revise targets.

#### 4.10 Corrective Actions for High-Priority Programs

Under Executive Order (EO) 13520 and its implementing guidance, OMB identifies programs that have more than \$750 million in annual estimated improper payments and that contribute substantially to the government-wide improper payment estimate. These programs, known as high-priority programs, are required to perform certain activities, including: selecting Accountable Officials to oversee the agency's improper payment efforts; posting improper payment information to [www.PaymentAccuracy.gov](http://www.PaymentAccuracy.gov); and developing supplemental measures in addition to the annual error rate measures.

HHS has five programs that OMB deemed high-priority programs: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, and CHIP. Accordingly, HHS has worked to meet the EO's additional requirements for its high-risk programs, and information on HHS's efforts can be found on [www.PaymentAccuracy.gov](http://www.PaymentAccuracy.gov). In addition, while root causes of errors in the Department's programs can fluctuate from year to year, HHS remains focused on reducing the annual error rates for its high-priority programs, and is taking many actions to prevent and reduce improper payments (see *Section 11.0* for more information on HHS's corrective actions).

#### 5.0 Accountability in Reducing and Recovering Improper Payments

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Strengthening program integrity throughout the organization is a top Departmental priority, extending to HHS senior executives and program officials at each of our agencies and programs. As evidence of this focus, beginning with senior leadership and cascading down, performance plans contain strategic goals that are related to strengthening program integrity, protecting taxpayer resources, and reducing improper payments. Senior Executives and programs officials are evaluated as part of their semi-annual and annual performance evaluations on their progress toward achieving these goals.

#### 6.0 Information Systems and Other Infrastructure

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*Section 11.0: Program-Specific Reporting Information* details each program's information systems and other infrastructure.

#### 7.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

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*Section 11.0: Program-Specific Reporting Information* reports each program's statutory or regulatory barriers, if any, to reduce improper payments.

## 8.0 Progress and Achievements

### 8.10 FY 2015 Progress

As of FY 2013, OMB no longer requires Head Start to report annual improper payment estimates, due to the strong internal controls, monitoring systems, and low reported error rates from FY 2009 through FY 2012 for the program. In lieu of an annual error rate measurement, HHS provides oversight through Head Start's existing internal controls and monitoring systems, and annually reports to OMB on its internal controls. For FY 2015, HHS continued to enhance onsite monitoring, mandatory annual visits, and the oversight activities of the Monitoring Disallowance Review Board. In addition, 45 Code of Federal Regulations (CFR) 1305 went into effect in March 2015 and requires more detail and accountability of eligibility practices. Overall, FY 2015 onsite monitoring results indicate the number of grantees with erroneous payments related to eligibility remained consistently low, even with an increase in the number of in-depth reviews to determine noncompliance with eligibility regulations.

### 8.20 FY 2015 Achievements

#### 8.21 Improving Program Integrity in Medicare and Medicaid

In FY 2015, HHS strengthened its efforts to reduce and recover improper payments in Medicare and Medicaid. While a few of these efforts are highlighted below, more detailed information on the FY 2015 Medicare and Medicaid programs' performance and corrective actions can be found in *Section 11.0: Program-Specific Reporting Information*.

##### ***CMS Program Integrity Board***

As part of HHS's efforts to reduce improper payments, CMS established an agency-wide Program Integrity Board (the Board) to identify and prioritize improper, wasteful, abusive, and potentially fraudulent payment vulnerabilities in its programs. The Board is comprised of CMS executive leaders, all of whom share the mutual objective to identify and prevent improper and fraudulent payments. After identifying high-priority vulnerabilities, the Board directs corrective actions and tracks issues to resolution.

##### ***Affordable Care Act Provider Enrollment Moratorium***

Section 6401 of the *Affordable Care Act* added new Section 1866(j)(7) to the *Social Security Act*, which provides HHS with the authority to impose a moratorium on the enrollment of new providers and suppliers to prevent or combat fraud, waste, or abuse in Medicare, Medicaid, or CHIP. On July 30, 2013, HHS launched the first temporary (six month) enrollment moratorium under the *Affordable Care Act* for Miami-area and Chicago-area home health agencies (HHAs) and ground ambulance suppliers in the Houston-area. On January 30, 2014, HHS extended the original moratoria for these locations and expanded the enrollment moratoria to include HHAs in the Ft. Lauderdale, Detroit, Dallas, and Houston areas. HHS also expanded the moratoria for ground ambulance suppliers into the Philadelphia area. Since that expansion, the moratoria have been extended three times in six-month increments for all areas, with the most recent moratoria extension effective July 29, 2015. The focus of these efforts is to prevent and deter fraud, waste, and abuse in high-risk services and areas across the country while ensuring beneficiary access to care.

##### ***Fraud Prevention System***

HHS launched the Fraud Prevention System (FPS) on June 30, 2011, as required by the *Small Business Jobs Act of 2010* (SBJA). The FPS analyzes all Medicare FFS claims prior to payment using risk-based algorithms developed by HHS and the private sector. HHS uses the FPS to target investigative resources, generating alerts for suspect claims or providers in priority order, to further investigate the most egregious, suspect, or aberrant activity. HHS and its

program integrity contractors use the FPS information to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement.

During the third implementation year of the FPS, defined in the SBJA as January 1, 2014 through December 31, 2014, HHS took administrative action against 1,093 providers resulting in an estimated \$454.0 million in identified savings. These savings were 80 percent higher than the savings from the previous implementation year, with a nearly 10 to 1 return on investment. The FPS also generated leads for 276 new investigations, and augmented information for 336 ongoing investigations. Information on these and other actions initiated through the FPS can be found in the FPS Reports to Congress, available at [www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html](http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html).

#### ***National Benefit Integrity Medicare Drug Integrity Contractor***

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) performs data analysis to proactively fight fraud, waste, and abuse in the Medicare Part C and D programs. The NBI MEDIC identifies improper payments as a result of data analysis and assists HHS with recovering the improper payments. NBI MEDIC referrals to law enforcement have resulted in sentences ordering restitution of \$41.4 million, forfeitures of \$13.6 million, and \$12.2 million in civil settlements according to FY 2015 notifications from law enforcement. As a result of the NBI MEDIC's data analysis projects, HHS recovered \$23.54 million in FY 2015 from Part D sponsors.

#### ***Medicaid Integrity Program***

Under the authority of Section 1936 of the *Social Security Act*, as amended by the *Deficit Reduction Act of 2005* (DRA), HHS's Medicaid Integrity Program has two broad responsibilities:

- To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.
- To provide effective support and assistance to states in their efforts to combat Medicaid provider fraud, waste, and abuse.

HHS analyzed Medicaid recoveries, which show there has been a strong focus on Medicaid integrity since the enactment of the DRA. For example, the Medicaid Integrity Program has provided the assistance of federal staff specializing in program integrity and contractor support to bolster state activities. Based on states' quarterly reports to HHS, this assistance resulted in \$656.89 million in total collections in FY 2015. The DRA also required HHS to establish a Comprehensive Medicaid Integrity Plan to guide the Medicaid Integrity Program's development and operations. HHS's most recent Comprehensive Medicaid Integrity Plan for FYs 2014 to 2018 is available at [www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf).

## **8.22 Public Assistance Reporting Information System**

The Public Assistance Reporting Information System (PARIS) is a federal/state partnership with all 50 states, the District of Columbia, and Puerto Rico that provides state public assistance agencies detailed information and data to maintain program integrity and detect and deter improper payments in TANF, Medicaid, Workers' Compensation, Child Care, and Supplemental Nutrition Assistance Program (SNAP).

HHS, the Department of Veterans Affairs (VA), and the Department of Defense (DOD) partnered to advance the PARIS project at no cost to states. The DOD's Defense Manpower Data Center (DMDC) provides computer resources to produce a match file, using Social Security numbers submitted by the states, VA, and DOD as the key match indicator. States verify the matched individual's eligibility and take any necessary action. HHS contributes to this effort by executing Computer Matching Agreements and coordinating the quarterly matches. Since its



establishment, PARIS has strengthened program administration among its programs and state public assistance agencies. For instance, two states reported that PARIS led to reported savings or cost avoidance of approximately \$99.3 million in FY 2015 alone. More information on this effective partnership can be found at: [www.acf.hhs.gov/programs/paris](http://www.acf.hhs.gov/programs/paris).

## 9.0 Improper Payment Reduction Outlook FY 2014 through FY 2018

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The following tables (Table 1A, Table 1B, and Table 1C) display HHS's improper payment results for the current year (CY) FY 2015, the prior year (PY) FY 2014, and targets for FYs 2016 through 2018. The tables include the following information by year and program, as applicable: FY outlays, the error rate or future reduction target (IP%), and dollars paid or projected to be paid improperly (IP\$). In addition, for the CY, HHS included: the amount of overpayments (CY Overpayments), the amount of underpayments (CY Underpayments), and the net error rate (CY Net IP%) and the corresponding overpayments (CY net IP\$), when available.

Table 1A includes improper payment information for HHS's OMB-determined risk-susceptible programs. Table 1B includes the FY 2015 improper payment results for the programs that received *Disaster Relief Act* funding and does not include out-year reduction targets for programs where all of the funds have been expended. Table 1C presents the Department's aggregate improper payment information.

**Table 1A**  
**Improper Payment Reporting for OMB-Determined Risk-Susceptible Programs**  
 FY 2014 - FY 2018 (in Millions)

Program or Activity	PY Outlays \$	PY IP %	PY IP \$	CY Outlays \$	CY IP %	CY IP \$	CY Over payment \$	CY Under payment \$	CY Net IP %	CY Net IP \$	CY+1 Est. Outlays \$	CY+1 IP %	CY+1 IP \$	CY+2 Est. Outlays \$	CY+2 IP %	CY+2 IP \$	CY+3 Est. Outlays \$	CY+3 IP %	CY+3 IP \$
Medicare FFS	360,173 Note (a)	12.7	45,754	358,348.60 Note (b)	12.09 Note (1)	43,325.61	42,068.35	1,257.26	11.39	40,811.09	393,521.05 Note (c)	11.50	45,254.92	414,857.11	10.40	43,145.14	436,331.52	9.40	41,015.16
Medicare Part C	135,513 Note (d)	9.0	12,229	148,593.71 Note (e)	9.50	14,117.00	10,265.04	3,851.96	4.32	6,413.08	204,161.00 Note (f)	9.14	18,660.32	204,215.00	8.79	17,950.50	201,568.00	8.79 Note (2)	17,717.83
Medicare Part D	58,493 Note (g)	3.3	1,931	62,003.91 Note (h)	3.60	2,234.25	1,825.75	408.50	2.29	1,417.25	96,504.00 Note (i)	3.40	3,281.14	99,806.00	3.30	3,293.60	97,389.00	3.20	3,116.45
Medicaid	261,613 Note (j)	6.7	17,492	297,672.02 Note (k)	9.78 Note (3)	29,124.61	28,627.51	497.10	9.45	28,130.41	336,988.39	11.53 Note (4)	38,854.76	365,842.60	10.48	38,340.30	364,453.62	7.36	26,823.79
CHIP	9,469 Note (l)	6.5	612	9,293.91 Note (m)	6.80 Note (5)	632.11	626.27	5.84	6.68	620.43	10,556.74	6.81 Note (4)	718.91	15,426.10	6.23	961.05	16,615.49	5.90	980.31
TANF	16,327 Note (n)	N/A	N/A	16,215.32 Note (o)	N/A Note (6)	N/A	N/A	N/A	N/A	N/A	17,160.38	N/A	N/A	17,129.20	N/A	N/A	17,034.92	N/A	N/A
Foster Care	1,198 Note (p)	5.5	66.2	841.01 Note (q)	3.65	30.68	28.20	2.48	3.06	25.72	728.70	3.60	26.23	823.40	3.55	29.23	841.01	3.50	29.44
Child Care	5,239 Note (r)	5.7	299	5,420.32 Note (s)	5.74	311.13	284.89	26.24	4.77	258.65	5,420.26	8.50 Note (7)	460.72	5,376.50	8.50	457.00	5,360.38	8.50	455.63
SUB-TOTAL Note (t)	831,698	9.4	78,383	882,173.48	10.18	89,775.39	83,726.01	6,049.38	8.81	77,676.63	1,047,880.14	10.24	107,257.00	1,106,346.71	9.42	104,176.82	1,122,559.02	8.03	90,138.61

Note: The Current Year (CY) CY+1, CY+2 and CY+3 estimated dollars paid improperly (IP\$) is calculated based on the target error rate and estimated outlays for each year, respectively. However, it is important to note that the measurement periods for each program vary. Therefore, the future outlay estimates presented may not be the actual amounts against which the error rates will be applied to compute the dollars paid improperly in future years.

### 9.10 Accompanying Improper Payment Reporting for OMB Determined Risk-Susceptible Programs Notes

- a) Medicare FFS PY outlays are from the FY 2014 Medicare FFS Improper Payments Report (based on claims from July 2012 – June 2013).
  - b) Medicare FFS CY outlays are from the FY 2015 Medicare FFS Improper Payments Report (based on claims from July 2013 – June 2014).
  - c) Medicare FFS CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review (Medicare Benefit Outlays current law (CL)).
  - d) Medicare Part C PY outlays reflect 2012 Part C payments, as reported in the FY 2014 Medicare Part C Payment Error Final Report.
  - e) Medicare Part C CY outlays reflect 2013 Part C payments, as reported in the FY 2015 Medicare Part C Payment Error Final Report.
  - f) Medicare Part C CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review (Medicare Benefit Outlays (CL)).
  - g) Medicare Part D PY outlays reflect 2012 Part D payments, as reported in the FY 2014 Medicare Part D Payment Error Final Report.
  - h) Medicare Part D CY outlays reflect 2013 Part D payments, as reported in the FY 2015 Medicare Part D Payment Error Final Report.
  - i) Medicare Part D CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review (Medicare Benefit Outlays (CL)).
  - j) Medicaid PY outlays (based on FY 2013 expenditures) are from the FY 2015 Midsession Review and exclude CDC Vaccine for Children program funding.
  - k) Medicaid CY (based on FY 2014 expenditures) and CY+1, CY+2, CY+3 outlays (Medicaid - Outlays (CL) exclude CDC Vaccine for Children program funding), are from the FY 2016 Midsession Review.
  - l) CHIP PY outlays (based on FY 2013 expenditures) are from the FY 2015 Midsession Review.
  - m) CHIP CY (based on FY 2014 expenditures) and CY+1, CY+2, CY+3 outlays (CHIP Total Benefit Outlays with *Children's Health Insurance Program Reauthorization Act* (CHIPRA) Bonus and Health Care Quality Provisions (CL)), are from the FY 2016 Midsession Review.
  - n) TANF PY outlays amount is based on the FY 2015 Midsession Review.
  - o) TANF CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs, and excluding the TANF Contingency Fund).
  - p) Foster Care PY outlays are based on the FY 2015 Midsession Review, and reflect the federal share of maintenance payments.
  - q) Foster Care CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review, and reflect the federal share of maintenance payments.
  - r) Child Care PY outlays are based on the FY 2015 Midsession Review.
  - s) Child Care CY, and CY+1, CY +2, CY+3 outlays are based on the FY 2016 Midsession Review.
  - t) The "Total" does not represent a true statistical estimate for the agency, and does not include information for TANF.
1. Beginning in FY 2012, in consultation with OMB, HHS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient hospital claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services (i.e., improper payments due to inpatient status reviews) should have been provided as outpatient services. HHS continued this methodology in FY 2013 and FY 2014. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed HHS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B.

HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been properly submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.38 percentage points to 12.09 percent or \$43.33 billion in projected improper payments. Additional information regarding the adjustment factor can be found on pages 166 – 167 of HHS's FY 2012 AFR (available at: [www.wayback.archive-it.org/3922/20131030171234/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171234/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

2. The Medicare Part C targets for CY+2 and CY+3 are held constant based on the uncertainty of out-year trends. The target for CY+3 will be re-evaluated after the FY 2016 reporting period.
3. HHS calculated and is reporting the national Medicaid error rate based on measurements that were conducted in FYs 2013, 2014 and 2015. The national Medicaid error component rates are: Medicaid FFS: 10.59 percent and Medicaid managed care: 0.12 percent. The Medicaid eligibility component improper payment rate is held constant at the FY 2014 reported rate of 3.11 percent as described in *Section 11.40* below.
4. The Medicaid and CHIP CY+1 IP% reduction target increased from the CY IP%. As described in *Section 11.41*, although all states are included in the improper payment rates, HHS only reviews 17 states each year. In FY 2014, HHS reported a rate reflecting the first 17 states measured under new requirements, which are described in *Section 11.42* and *11.52* as drivers of the Medicaid and CHIP improper payment rates. The FY 2015 improper payment rates reflect the second group of 17 states subject to new requirements for a total of 34 states. In FY 2016, HHS will report a rate that reflects the measurement of the final group of 17 states subject to new requirements, and will be the first baseline improper payment rate reflecting measurement of all states under the new requirements. HHS expects to see a decrease in the following years due to corrective actions as states are measured again.
5. HHS calculated and is reporting the national CHIP error rate based on measurements that were conducted in FYs 2013, 2014, and 2015. The national CHIP error component rates are: CHIP FFS: 7.33 percent and CHIP managed care: 0.37 percent. The CHIP eligibility component improper payment rate is held constant at the FY 2014 reported rate of 4.22 percent as described in *Section 11.50* below.
6. The TANF program is not reporting an error rate for FY 2015. Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. Please see *Section 11.60* for additional information on statutory limitations to establishing a TANF improper payment measurement.
7. The *Child Care and Development Block Grant Act of 2014* (CCDBG) reauthorized the Child Care and Development Fund program for the first time since 1996. HHS measures one-third of the Child Care grantees each year. HHS established a slight increase in the improper payment target rates to accommodate all reporting cohorts' implementation of the sweeping policy and procedure changes under the new CCDBG statute. As each reporting cohort completes reviews in the next three years, HHS anticipates that error rates will increase as new policies are implemented and reviewed. Future targets may be adjusted as well, depending on future performance.

**Table 1B**  
**Improper Payment Reporting for Superstorm Sandy Programs**  
 FY 2014 - FY 2018 (in Millions)

Program or OpDiv	PY Outlays \$	PY IP %	PY IP \$	CY Outlays \$	CY IP %	CY IP \$	CY Over payment \$	CY Under payment \$	CY Net IP %	CY Net IP \$	CY+1 Est. Outlays \$	CY+1 IP %	CY+1 IP \$	CY+2 Est. Outlays \$	CY+2 IP %	CY+2 IP \$	CY+3 Est. Outlays \$	CY+3 IP %	CY+3 IP \$
ACF Head Start	3.93	0	0	16.38	0.38	0.0616	0.0616	0	0.38	0.0616	49.02	0.34	0.167	25.26	0.30	0.076	N/A	N/A	N/A
ACF Social Services Block Grant	67.03	13.5	9.04	209.14	0.22 Note (8)	0.464	0.458	0.006	0.22	0.452	79.55	0.21	0.17	79.55	0.20	0.16	N/A	N/A	N/A
ACF Family Violence Prevention and Services	0.14	4.4	0.006	0.893	0.89	0.00794	0.00794	0	0.89	0.00794	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ASPR Research	0 Note (9)	0	0	1.55	0	0	0	0	0	0	3.055	0	0	N/A	N/A	N/A	N/A	N/A	N/A
CDC Research	1.82	0	0	4.6	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SAMHSA	0.42	12.7	0.05	1.32	1.38	0.0182	0.0101	0.0081	0.15	0.002	0.60 Note 10	1.00	0.006	N/A	N/A	N/A	N/A	N/A	N/A
NIH Research	32.05	0.002	.000741	38.60	2.29	0.885	0.885	0	2.29	0.885	9.73	2.29 Note 11	0.223	N/A	N/A	N/A	N/A	N/A	N/A
Sub-Total Note (12)	105.39	8.63	9.10	272.483	0.53	1.437	1.423	0.014	0.517	1.409	141.955	0.40	0.566	104.81	0.23	0.24	N/A	N/A	N/A

## 9.20 Accompanying Improper Payment Reporting for Superstorm Sandy Programs Notes

8. ACF SSBG's FY 2014 reviews consisted only of a case record review in New Jersey. For the FY 2015 review period, HHS completed case record and vendor payment reviews for Connecticut, New York, and New Jersey. In FY 2015, the case record component error rate was 1.18 percent, and the vendor payment error rate was 0.18 percent. Additional information on the error rate for the case record reviews and vendor payments—both of which comprise the national error rate – can be found in *Section 15.20*.
9. ASPR Research's FY 2014 and FY 2015 measurement period was based on the previous FY. ASPR Research reported \$0 in PY outlays since they awarded grants late in FY 2013 and their grantees did not begin expending funds until FY 2014.

10. SAMHSA's CY+1 outlays are based on remaining funds that could potentially be spent by grantees. This total may be restated in the FY 2016 AFR.
11. NIH Research is projecting to maintain its error rate of 2.29 percent in FY 2016. NIH expects that its error rate will remain constant in FY 2016 due to projected difficulties obtaining documentation from grantees, and the Disaster Relief Act's requirement that all funding be expended within two years.
12. The "Total" does not represent a true statistical estimate for the agency.

**Table 1C**  
**Improper Payment Reporting for All Programs**  
 FY 2014 - FY 2018 (in Millions)

Name	PY Outlays \$	PY IP %	PY IP \$	CY Outlays \$	CY IP %	CY IP \$	CY Over payment \$	CY Under payment \$	CY Net IP %	CY Net IP \$	CY+1 Est. Outlays \$	CY+1 IP %	CY+1 IP \$	CY+2 Est. Outlays \$	CY+2 IP %	CY+2 IP \$	CY+3 Est. Outlays \$	CY+3 IP %	CY+3 IP \$
Sub-Total of OMB Determined Risk-Susceptible Programs from Table 1A	831,698	9.4	78,383.20	882,173.48	10.18	89,775.39	83,726.01	6,049.38	8.81	77,676.63	1,047,880.14	10.24	107,257.00	1,106,346.71	9.42	104,176.82	1,122,559.02	8.03	90,138.61
Sub-Total of Superstorm Sandy Programs from Table 1B	105.39	8.63	9.10	272.483	0.53	1.437	1.423	0.014	0.517	1.409	141.955	0.40	0.566	104.81	0.23	0.24	N/A	N/A	N/A
<b>TOTAL ALL PROGRAMS Note (12)</b>	<b>831,803.39</b>	<b>9.4</b>	<b>78,392.30</b>	<b>882,445.963</b>	<b>10.17</b>	<b>89,776.827</b>	<b>83,727.433</b>	<b>6,049.394</b>	<b>8.80</b>	<b>77,678.039</b>	<b>1,048,022.095</b>	<b>10.23</b>	<b>107,257.566</b>	<b>1,106,451.52</b>	<b>9.42</b>	<b>104,177.06</b>	<b>1,122,559.02</b>	<b>8.03</b>	<b>90,138.61</b>

## 10.0 Improper Payment Root Cause Categories

Appendix C to OMB Circular A-123, which was updated and released in October 2014, requires the reporting of improper payment root causes by agencies with high-risk programs. The following tables display HHS's improper payment root causes for FY 2015 for each high-risk program. There is a separate column for each program. The tables include categories of improper payments and the amount of overpayment or underpayment associated with each improper payment category. Additional information on the root causes, and corrective actions, for each high-risk program can be found in each program-specific reporting section.

**Table 2A**  
**Medicare Improper Payment Root Cause Category Matrix**  
FY 2015 (in Millions)

Reason for Improper Payment		Medicare FFS		Medicare Part C <sup>Note 1</sup>		Medicare Part D <sup>Note 2</sup>	
		Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue							
Inability to Authenticate Eligibility							
Failure to Verify:	Death Data						
	Financial Data						
	Excluded Party Data						
	Prisoner Data						
	Other Eligibility Data (explain)						
Administrative or Process Error Made by:	Federal Agency						
	State or Local Agency						
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	\$4,850.21	\$1,257.03		\$3,851.96		\$408.50
Medical Necessity		\$7,502.84	\$0.23				
Insufficient Documentation to Determine		\$29,715.30		\$10,265.04		\$1,825.75	
<b>TOTAL</b>		<b>\$42,068.35</b>	<b>\$1,257.26</b>	<b>\$10,265.04</b>	<b>\$3,851.96</b>	<b>\$1,825.75</b>	<b>\$408.50</b>

**Notes:**

- Underpayments in the Medicare Part C program occur when plans do not submit relevant diagnosis information for payment, but are subsequently found by HHS during medical record review.
- Underpayments in the Medicare Part D program are mainly due to discrepancies in prescription drug event documentation.

**Table 2B**  
**Medicaid and CHIP Improper Payment Root Cause Category Matrix**  
 FY 2015 (in Millions) <sup>Note 3</sup>

Reason for Improper Payment		Medicaid		CHIP	
		Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue					
Inability to Authenticate Eligibility		\$8,509.11	\$244.17	\$371.71	\$4.05
Failure to Verify:	Death Data				
	Financial Data				
	Excluded Party Data				
	Prisoner Data				
	Other Eligibility Data (explain)				
Administrative or Process Error Made by:	Federal Agency				
	State or Local Agency	\$16,718.23	\$263.51	\$169.02	\$1.63
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	\$795.46	\$14.49	\$15.40	\$0.35
Medical Necessity		\$1.36		\$0.09	
Insufficient Documentation to Determine		\$2,603.35		\$70.05	
<b>TOTAL</b>		\$28,627.51	\$522.17	\$626.27	\$6.03

## Notes:

3. The Medicaid and CHIP underpayment totals reported in this table are greater than the underpayment totals displayed in Table 1A, which excludes underpayments that may have also been counted as overpayments.



**Table 2C**  
**Foster Care and Child Care Improper Payment Root Cause Category Matrix**  
FY 2015 (in Millions)

Reason for Improper Payment		Foster Care		Child Care	
		Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue					
Inability to Authenticate Eligibility					
Failure to Verify:	Death Data				
	Financial Data				
	Excluded Party Data				
	Prisoner Data				
	Other Eligibility Data (explain)				
Administrative or Process Error Made by:	Federal Agency				
	State or Local Agency	\$28.20	\$2.48	\$226.74	\$26.24
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)				
Medical Necessity					
Insufficient Documentation to Determine				\$58.15	
Other Reason (a) (explain)					
Other Reason (b) (explain)					
<b>TOTAL</b>		<b>\$28.20</b>	<b>\$2.48</b>	<b>\$284.89</b>	<b>\$26.24</b>

**Table 2D**  
**ACF Superstorm Sandy Improper Payment Root Cause Category Matrix**  
FY 2015 (in Millions)

Reason for Improper Payment		Head Start		Social Services Block Grant		Family Violence Prevention and Services	
		Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue							
Inability to Authenticate Eligibility							
Failure to Verify:	Death Data						
	Financial Data						
	Excluded Party Data						
	Prisoner Data						
	Other Eligibility Data (explain)						
Administrative or Process Error Made by:	Federal Agency						
	State or Local Agency	\$0.0616		\$0.2488	\$0.000021	\$0.00794	
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)			\$0.0603	\$0.006381		
Medical Necessity							
Insufficient Documentation to Determine				\$0.1484			
TOTAL		\$0.0616		\$0.458	\$0.006	\$0.00794	

**Table 2E**  
**ASPR, CDC, SAMHSA, and NIH Superstorm Sandy Improper Payment Root Cause Category Matrix**  
FY 2015 (in Millions)

Reason for Improper Payment		ASPR Research		CDC Research		SAMHSA		NIH Research	
		Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue									
Inability to Authenticate Eligibility									
Failure to Verify:	Death Data								
	Financial Data								
	Excluded Party Data								
	Prisoner Data								
	Other Eligibility Data (explain)								
Administrative or Process Error Made by:	Federal Agency								
	State or Local Agency								
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)					\$0.0101	\$0.0081		
Medical Necessity									
Insufficient Documentation to Determine								\$0.885	
TOTAL						\$0.0101	\$0.0081	\$0.885	

## 11.0 Program-Specific Reporting Information

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### 11.10 Medicare FFS (Parts A and B)

#### 11.11 Medicare FFS Statistical Sampling Process

Medicare FFS uses the Comprehensive Error Rate Testing (CERT) program to calculate the improper payment estimate. The CERT program considers any claim paid when it should have been denied or was paid in the wrong amount (including both overpayments and underpayments) to be an improper payment. To meet this objective, a stratified random sample of Medicare FFS claims is reviewed to determine if claims were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or partial improper payment, depending on the error category. Approximately 49,600 claims were sampled during the FY 2015 report period. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample reflects all claims processed by the Medicare FFS program during the report period. Additional information on the Medicare FFS improper payment methodology can be found on pages 166 – 167 of HHS's FY 2012 AFR, available at: [http://wayback.archive-it.org/3922/20131030171234/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://wayback.archive-it.org/3922/20131030171234/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

The Medicare FFS gross improper payment estimate for FY 2015 is 12.09 percent or \$43.33 billion. The FY 2015 net improper payment estimate is 11.39 percent or \$40.81 billion. The factors contributing to improper payments are complex and vary from year to year.

The primary causes of improper payments are insufficient documentation and medical necessity errors. Insufficient documentation was particularly prevalent for home health claims. The improper payment rate for home health claims increased from 51.38 percent in FY 2014 to 58.95 percent in FY 2015 due to the documentation requirements to support the medical necessity of the services.

Insufficient documentation was also common for Skilled Nursing Facility (SNF) claims. The improper payment rate for SNF claims increased from 6.94 percent in FY 2014 to 11.04 percent in FY 2015.

#### 11.12 Medicare FFS CAP

The primary cause of improper payments is lack of documentation to support the services or supplies billed to Medicare, or Insufficient Documentation to Determine errors (68.6 percent). The other causes of improper payments are classified as Medical Necessity errors (17.3 percent) and Administrative or Process Errors Made by Other Party (14.1 percent), due to incorrect coding errors. HHS is committed to reducing improper payments in the Medicare FFS program. HHS uses data from the CERT program and other sources to reduce or eliminate improper payments through various corrective actions. Each year, HHS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. While some corrective actions have been implemented, others are in the early stages of implementation. HHS believes these focused corrective actions will have a larger impact over time as they become integrated into business operations.

Of particular importance are five corrective actions that HHS believes will have a considerable effect in preventing and reducing improper payments.

- First, HHS continues to implement corrective actions to address program payment vulnerabilities related to home health services.
  - HHS issued a final rule, CMS-1611-F (79 FR 66031, November 6, 2014) to update Medicare's Home Health Prospective Payment System payment rates and wage index for calendar year

2015. In this rule, HHS finalized changes to the face-to-face requirements for episodes beginning on or after January 1, 2015. HHS believes clarifying the face-to-face requirements will lead to a decrease in these errors and improve provider compliance with regulatory requirements, while continuing to strengthen the integrity of the Medicare programs. Specifically, HHS amended the HHA regulation to remove the requirement for the physician narrative as part of the certification of patient eligibility for the benefit, which was required to certify that the home health patient eligibility criteria have been met. Now reviewers can consider all entries in the medical record as supporting documentation when determining medical necessity.

- HHS created voluntary draft paper and electronic clinical templates for ordering physicians and ordering hospitals to serve as progress notes and discharge summaries. These templates are currently in the clearance process. The templates will help physicians and hospital staff capture the information needed to complete the face-to-face encounter documentation and will become part of the medical record upon completion.
- On October 1, 2015, HHS's Medicare Administrative Contractors (MACs) began pre-payment reviews of home health claims for episodes beginning on or after August 1, 2015, using a Probe and Educate strategy designed to help HHAs understand the new patient certification requirements.
- Second, HHS proposed an update to the "Two Midnight" rule CMS-1633-P (70 FR Volume 80, Number 130, July 8, 2015) regarding when hospital admissions are appropriate for payment under Medicare Part A. At the same time, HHS notified the public of the following two upcoming changes in education and enforcement strategies.
  - Beginning on October 1, 2015, the Quality Improvement Organizations (QIOs) assumed responsibility to conduct initial patient status review of providers to determine the appropriateness of Part A payment for short stay inpatient hospital claims. From October 1, 2015 through December 31, 2015, short stay inpatient hospital reviews conducted by the QIOs will be based on Medicare's current payment policies.
  - Beginning on January 1, 2016, QIOs and Recovery Audit Contractors (RACs) will conduct patient status reviews in accordance with policy changes finalized in the Hospital Outpatient Prospective Payment System rule (CMS-1613-P) and effective in calendar year 2016. Effective January 1, 2016, RACs may conduct patient status reviews only for those providers that have been referred by the QIO as exhibiting persistent noncompliance with Medicare payment policies.
- Third, HHS issued a proposed rule that would build on a successful demonstration program to establish a Master List of Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization and potentially could be subject to prior authorization, as well as a Required Prior Authorization List of certain DMEPOS items that would be subject to a prior authorization process.
- Fourth, HHS expanded the use of prior authorization in the Medicare FFS program.
  - On September 1, 2012, HHS instituted a prior authorization demonstration program in seven states with the expectation of reducing improper payments for power mobility devices (PMDs). This demonstration project led to a decrease in the expenditures for PMDs in both the demonstration and non-demonstration states. Specifically, based on claims submitted as of August 14, 2015, monthly expenditures for the PMD codes included in the demonstration project decreased from \$10 million in September 2012 to \$3 million in June 2015 in the non-demonstration states and from \$22 million to \$5 million in the demonstration states. Prior authorization reviews are being performed timely and feedback from the industry and beneficiaries has been largely positive. HHS leveraged this success by expanding the demonstration to an additional 12 states (Arizona, Georgia, Indiana, Kentucky, Louisiana,

Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington) effective October 1, 2014, bringing the total number of states participating in the demonstration to 19. HHS also extended the demonstration to August 31, 2018 in FY 2015.

- Fifth, in FY 2015 HHS implemented two demonstration projects to test whether prior authorization in Medicare FFS reduces expenditures while maintaining or improving quality of care for certain non-emergent services. These projects will also ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before rendering services and paying claims.
  - In December 2014, HHS implemented a prior authorization demonstration program for repetitive, scheduled non-emergent ambulance transport occurring on or after December 15, 2014 in New Jersey, Pennsylvania, and South Carolina. Section 515 of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) expands the prior authorization model for repetitive scheduled non-emergent ambulance transports effective no later than January 1, 2016 to five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia.
  - HHS implemented a prior authorization demonstration program for non-emergent hyperbaric oxygen therapy in Michigan, Illinois, and New Jersey. Providers in Michigan could begin submitting prior authorization requests on March 1, 2015, and providers in Illinois and New Jersey could begin submitting prior authorization requests on July 14, 2015.

In addition to these five major efforts and the ongoing corrective actions reported on pages 165 - 167 of HHS's FY 2013 AFR ([www.hhs.gov/afr/fy2013-other-information.pdf](http://www.hhs.gov/afr/fy2013-other-information.pdf)), HHS has implemented additional efforts in specific areas to reduce improper payments in the Medicare FFS program as outlined below.

### **Corrective Actions to Address Root Causes:**

#### ***Root Cause: Administrative or Process Errors Made by Other Party***

- Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, HHS relies on automated edits to identify many inappropriate claims. HHS designed its systems to detect anomalies on the face of the claims, and through these efforts, HHS correctly pays submitted claims nearly 100 percent of the time. For example, HHS uses the National Correct Coding Initiative (NCCI) to stop claims that never should be paid. This program prevents payments for services such as a hysterectomy for a man or a prostate exam for a woman. The use of the NCCI edits saved the Medicare program \$681.9 million in FY 2014.
- The *Affordable Care Act* required HHS to revalidate all existing Medicare providers and suppliers. All Medicare providers and suppliers already enrolled prior to the new screening requirements becoming effective were sent revalidation notices by March 23, 2015. HHS has requested the revalidation of all 1.6 million existing Medicare providers to ensure that only qualified and legitimate providers and suppliers can deliver health care items and services to Medicare beneficiaries. These revalidation efforts alone resulted in the deactivation of more than 307,388 provider and supplier practice locations as well as the revocation of 17,655 providers' and suppliers' billing privileges.
- HHS continues to build the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse. Public and private partners, including federal and state partners, private payers, associations, and law enforcement exchange data and anti-fraud practices within the HFPP, helping to prevent and detect fraud across sectors.
- HHS and its contractors develop medical review strategies using the improper payment data to ensure the areas of highest risk and exposure are targeted. HHS requires its Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in certain error prone claim types, such as home health, hospital outpatient, and skilled nursing facility (SNF) claims.

**Root Cause: Medical Necessity and Insufficient Documentation to Determine**

- HHS contracted with a Supplemental Medical Review/Specialty Contractor (SMRC) to perform medical reviews focused on vulnerabilities identified by HHS internal data analysis, the CERT program, professional organizations, and federal oversight agencies. The contractor evaluates medical records and related documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules. In FY 2015 the SMRC performed post payment reviews on certain durable medical equipment items, such as continuous positive airway pressure devices, portable oxygen concentrators, and nebulizer medications and equipment. The SMRC also reviewed high cost diagnostic imaging and blepharoplasty procedures. The results of these reviews are used to improve billing accuracy.
- HHS continues to allow review contractors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. In February 2014, HHS announced a number of changes to the Medicare FFS RAC program that will take effect with the new contract awards as a result of stakeholder feedback. HHS believes that these improvements will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency. For further information on these changes, refer to [www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/downloads/RAC-program-improvements.pdf](http://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/downloads/RAC-program-improvements.pdf).
- HHS issues Comparative Billing Reports (CBRs) to help non-hospital providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements that enable providers to examine their billing patterns compared to their peers in the state and across the nation.
- HHS published CMS-6010-F, "Medicare and Medicaid Programs: Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements and Changes in Provider Agreements" (77 FR 25283), on April 27, 2012. Effective January 6, 2014, this rule requires physicians and other professionals who order and certify certain covered items and services for Medicare beneficiaries, including the following: home health, clinical laboratory, imaging and DMEPOS, to be a Medicare participating provider. Finally, it establishes document retention and access to documentation requirements for providers and suppliers that order and certify certain items and services for Medicare beneficiaries.

**11.13 Medicare FFS Improper Payment Recovery**

The actual overpayments identified by the CERT program during the FY 2015 report period were \$39,710,413.13. The identified overpayments are recovered by the MACs via standard payment recovery methods. As of the report publication date, MACs reported collecting \$30,684,727.80 or 77.27 percent of the actual overpayment dollars identified in the report.

**11.14 Medicare FFS Information Systems and Other Infrastructure**

HHS has the information systems and other infrastructure it needs to reduce improper Medicare FFS payments to the targeted levels. HHS's systems have the ability to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with national rates. The systems at both the Medicare contractor level and the HHS level are tied together by a high-speed secure network that allows rapid transmission of large data sets between systems. In addition, HHS continuously reviews opportunities for centralizing the development and implementation of automated edits based on national coverage determinations, medically unlikely units billed, and other relevant parameters to prevent improper payments on a prepayment basis. No other systems or infrastructure are needed at this time.

### 11.15 Medicare FFS Statutory or Regulatory Barriers That Could Limit Corrective Actions

Current law limits HHS's authority to conduct prior authorization on services that account for a large portion of the overall Medicare FFS improper payments. Section 1834(a)(15) of the *Social Security Act* authorizes the Secretary to develop and periodically update a list of DMEPOS determined, on the basis of prior payment experience, to be subject to unnecessary utilization and to develop a prior authorization process for these items. However, current law does not allow for prior authorization of any other claim types or services. As a result, the FY 2016 President's Budget proposed amending Section 1893 of the *Social Security Act* to give the Secretary the discretion to select items or services for prior authorization without rulemaking where the items or services involve high cost, high utilization, patient risk, and/or high improper payment rates.

### 11.16 Medicare FFS Best Practices

HHS has incorporated the following best practices to ensure the highest degree of efficiency:

- HHS made significant progress in driving innovation and improvement in reducing fraud and improper payments by holding collaborative sessions with multi-disciplinary teams to develop consistent approaches for investigation and action at the Program Integrity Command Center.
- HHS works with state Medicaid data in the Medicare-Medicaid Data Match program (Medi-Medi program). HHS designed the program to collaborate with participating state Medicaid agencies on billing trends across the Medicare and Medicaid programs. HHS analyzes matched data to identify potential fraud, waste, and abuse patterns. Analysis performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making the program an important tool in identifying and preventing fraud and improper payments.
- HHS conducts re-reviews of certain claims that have been medically reviewed by the MACs to ensure accurate decisions are made and that Medicare policies are applied consistently across the program.
- CERT contractors collaborate with other review contractor entities, such as the MACs and Medicare FFS RACs, to clarify unclear policies, in an effort to ensure review consistency.
- HHS provides interim improper payment rate data to the MACs to help them focus on problematic areas and identify emerging vulnerabilities.

In addition, HHS continues to improve the Medicare FFS improper payment rate measurement program to ensure that providers and suppliers submit the required documentation. Such improvements include:

- HHS coordinates provider outreach and education task forces. These task forces consist of Medicare Administrative Contractors (MAC) medical review professionals who meet regularly to develop provider education strategies and materials addressing areas prone to improper payments. The task forces hold open door forums to discuss documentation requirements and answer provider and supplier questions, and distribute informational articles as needed to improve documentation and to educate providers on Medicare policies. The articles are maintained online on the Medicare Learning Network (MLN) and can be accessed by the public at the MLN website: [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/mlngeninfo](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/mlngeninfo).
- HHS conducts ongoing education to inform providers and suppliers about the importance of submitting thorough and complete documentation. This education involves national training sessions, individual meetings with providers or suppliers with high improper payment rates, presentations at industry association meetings, and the dissemination of educational materials.
- HHS revises medical record request letters, as needed, to clarify the components of the medical record required for CERT review. The letter serves as a checklist for the provider or supplier to ensure their



record submission is complete. Follow-up medical record request letters have also been developed to explain what missing documentation needs to be submitted.

- When a supplier is contacted for documentation, the CERT program notifies the ordering provider that they may be contacted by the supplier in order to provide supporting documentation. In addition to this notification, the CERT program contacts third party providers to request documentation when the billing provider indicates that a portion of the medical record is possessed by a third party. For example, a third party provider may be a hospital that possesses the record for professional services provided by a billing physician while the beneficiary was hospitalized.

## 11.20 Medicare Advantage

### 11.21 Medicare Advantage Statistical Sampling Process

The FY 2015 Medicare Part C gross improper payment estimate is 9.50 percent or \$14.12 billion. The FY 2015 net improper payment estimate is 4.32 percent or \$6.41 billion. The increase from the prior year's reported error estimate was due to a reduction in the magnitude of risk adjusted diagnoses that were not submitted by Medicare Advantage (MA) Organizations for payment.

The Part C methodology estimates errors resulting from incorrect beneficiary risk scores. The primary component of a beneficiary's risk score is based on clinical diagnoses submitted by plans. If the diagnoses submitted to HHS are not supported by medical records, the risk scores will be inaccurate and result in payment errors. The Part C estimate is based on medical record reviews conducted under HHS's annual Risk Adjustment Data Validation (RADV) process, where unsupported diagnoses are identified and corrected risk scores are calculated.

The FY 2015 methodology consists of the following steps:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in calendar year 2013, where the strata are high, medium, and low risk scores,
- Medical record review of the diagnoses submitted by plans for the sampled beneficiaries,
- Calculation of beneficiary-level payment error for the sample, and
- Extrapolation of the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount.

### 11.22 Medicare Advantage CAPs

The root causes of FY 2015 Medicare Part C improper payments resulted from errors due to Insufficient Documentation to Determine (72.7 percent) and Administrative or Process Errors Made by Other Party (the Medicare Advantage (MA) organizations) (27.3 percent).

#### Corrective Actions to Address Root Causes:

##### ***Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party***

HHS has implemented two key corrective actions to address the Part C improper payment rate: contract-level audits and new regulatory provisions.

- ***Contract-Level Audits:*** HHS is proceeding with the RADV contract-level audits to recover overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. RADV audits are HHS's primary corrective action to recoup improper payments. HHS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted by plans for payment. RADV audits of payment year 2011, which began in

FY 2014, will be the first HHS reviews to recoup funds based on extrapolated estimates. In addition, payment year 2012 audits were initiated in FY 2015, and plans have been selected for audit.

- *New Regulatory Provisions:* In CMS-4159-F, “Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program” (79 FR 100), HHS codified the *Affordable Care Act* requirement that MA organizations must report and return overpayments that they identify. In CMS-1613-F, “The Calendar Year 2015 OPPS/ASC Rule” (79 FR 66769), HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by an MA organization.

### 11.23 Medicare Advantage Program Improper Payment Recovery

The Part C error estimate is based on a national sample of beneficiaries across all MA plans. Since this type of sample design does not allow for collection at the MA plan level, no payment recovery had been initiated until FY 2012, when HHS recovered approximately \$3.4 million for the first five plans involved in the 2007 RADV audits. Payment recovery for the pilot audits has been completed and totaled \$13.7 million (\$5.4 million was recovered in FY 2014, \$5.0 million in FY 2013, and \$3.4 million in FY 2012)<sup>24</sup>. Once the appeals process is complete, adjustments to the overpayment recoveries will be made. In addition, in FY 2015, MA organizations have reported and returned approximately \$650 million in overpayments, which appears to be the result of the sentinel effect of the RADV audits, as well as the ‘report and repay’ requirement, outlined above.

### 11.24 Medicare Advantage Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Medicare Part C payments. HHS uses the following internal Medicare systems to make and validate the Medicare Part C payments: the Medicare Beneficiary Database, the Risk Adjustment System, the Health Plan Management System, and the Medicare Advantage Prescription Drug (MARx) payment system. No other systems or infrastructure are needed at this time.

### 11.25 Medicare Advantage Statutory or Regulatory Barriers that Could Limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 11.26 Medicare Advantage Program Best Practices

HHS has taken several steps to ensure payment accuracy in the Part C program, including the corrective actions that were outlined earlier in *Section 11.22*.

### 11.30 Medicare Prescription Drug Benefit

#### 11.31 Medicare Prescription Drug Benefit Statistical Sampling Process

The Medicare Part D gross improper payment estimate for FY 2015 is 3.60 percent or \$2.23 billion. The FY 2015 net improper payment estimate is 2.29 percent or \$1.42 billion. The primary factor that drove the program’s increase from the prior year’s reported error estimate was an increase in the prescription drug event data validation component of the error rate.

<sup>24</sup> Values do not total due to rounding.

The FY 2015 Part D Composite Payment Error Rate combines four component payment error measures:

- Payment Error Related to Low Income Subsidy Status (PELS),
- Payment Error Related to Medicaid Status (PEMS),
- Payment Error Related to Prescription Drug Event Data Validation (PEPV), and
- Payment Error Related to Direct and Indirect Remuneration (PEDIR).

Combining these four component measures poses complex technical and statistical challenges in calculating a confidence interval for the composite rate. As a result, HHS calculated the precision level for each component independently, and each component meets OMB precision requirements.

The FY 2015 national Part D improper payment rate for each component is:

- *PELS*: 0.09 percent
- *PEMS*: 0.22 percent
- *PEPV*: 3.21 percent
- *PEDIR*: 0.09 percent

The methodology for calculating the PELS, PEMS, PEPV, and PEDIR rates was not altered from previous years. A description of the methodology is on pages 173 - 175 of HHS's FY 2012 AFR ([www.wayback.archive-it.org/3922/20131030171234/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171234/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

### 11.32 Medicare Prescription Drug Benefit CAP

The root causes of the FY 2015 Part D improper payments are Insufficient Documentation to Determine (81.7 percent) and Administrative or Process Error made by Other Parties (18.3 percent).

#### Corrective Actions to Address Root Causes:

##### ***Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party***

HHS conducted the following corrective actions to address errors:

- *Training*: HHS will continue its national training sessions for Part D sponsors on Part D payment and data submission.
- *Outreach*: Formal outreach to plan sponsors will continue for invalid/incomplete documentation.
  - HHS distributed Plan Sponsor Summary Reports to all plans participating in the PEPV component of the national payment error estimate. This report provided feedback on their submission and validation results against an aggregate of all other participating plan sponsors.
  - HHS distributed notices of non-compliance to plan sponsors who failed to provide documentation for the PEPV component of the national payment error estimate.
  - In December 2014, HHS conducted a listening session with several stakeholders from the Long Term Care and Long Term Care Pharmacy industry to get feedback on how to resolve a trend of missing or invalid signatures on Long Term Care medication orders selected for the PEPV audit.
- *New Regulatory Provisions*: HHS codified the *Affordable Care Act* requirement that Part D sponsors must report and return overpayments that they identify. HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by a Part D sponsor (See *Section 11.22* for more information on the rules).

### 11.33 Medicare Prescription Drug Benefit Improper Payment Recovery

HHS conducted the following improper payment recovery activities in FY 2015 for each error rate component:

- *PELS Component:* Further investigation must be done to better determine how to conduct payment recovery.
- *PEMS Component:* Application of the national Medicaid active case eligibility error rate to Part D payments does not allow HHS to identify which dual eligible beneficiaries actually had incorrect Medicaid status. Thus, it is not possible to identify beneficiary-level payments that HHS could recover.
- *PEPV Component:* The FY 2015 Prescription Drug Event (PDE) validation is based on a national sample of PDEs and the imputation of these results onto the Part D population; therefore, payment errors cannot be linked to specific beneficiaries for payment recovery purposes.
- *PEDIR Component:* The data used to develop the FY 2015 error rate were based on 2013 audits. Plans submit updates to their reported direct and indirect remuneration amounts throughout the year. HHS will, therefore, address payment recovery through the 2013 Part D reconciliation.

In addition, in FY 2015, approximately \$11.6 million in overpayments have been reported and returned. This recovery of Part D risk adjustment related overpayments appears to be the result of the 'report and repay' requirement described in the prior section.

### 11.34 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Medicare Part D payments. HHS uses the following internal Medicare systems to make and validate the Part D payments: the Medicare Beneficiary Database, the Risk Adjustment System, the Health Plan Management System, the MARx payment system, and the Integrated Data Repository. No other systems or infrastructure are needed at this time.

### 11.35 Medicare Prescription Drug Benefit Statutory or Regulatory Barriers that Could Limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 11.36 Medicare Prescription Drug Benefit Program Best Practices

In addition to the corrective actions outlined in *Section 11.32*, HHS has taken steps to ensure payment accuracy in the Medicare Part D program, including: (1) contacting plans before and during the PEPV data collection and validation process, which provides an open forum for improving instructions for data submission, and (2) extending the data collection period, which increased response rates.

## 11.40 Medicaid

### 11.41 Medicaid Statistical Sampling Process

The national FY 2015 Medicaid improper payment rate is based on measurements conducted in FYs 2013, 2014, and 2015. Medicaid improper payments are estimated on a federal fiscal year (FY) basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components. The eligibility component measurement is currently on hold as described in the eligibility component section that follows.

The Payment Error Rate Measurement (PERM) program uses a 17 state three-year rotation for measuring Medicaid improper payments. To see how HHS grouped states into three cycles, refer to pages 177 - 179 of HHS's FY 2012 AFR ([www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

### ***FFS and Managed Care Component***

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. The FFS sample size was between 292 and 966 claims per state and the managed care sample size was between 230 and 280 payments per state. The sample sizes were based on each state's historical FFS and managed care improper payment rate data. When a state's FFS component or managed care component accounted for less than two percent of the state's total Medicaid expenditures, the state's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred in six states.

### ***Eligibility Component***

In light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the *Affordable Care Act*, HHS will update the eligibility component measurement methodology and related PERM program regulation to reflect these changes. In August 2013 and October 2015, HHS released guidance announcing temporary changes to PERM eligibility reviews. For FYs 2015 through 2018, HHS will not conduct the eligibility measurement component of PERM. During this time period, the national Medicaid eligibility improper payment rate will be held constant at the FY 2014 reported rate of 3.11 percent.

In place of the FYs 2015 through 2018 PERM eligibility reviews, all states are required to conduct eligibility review pilots. The eligibility review pilots provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors.

### ***Calculations and Findings***

The national Medicaid program improper payment rate represents the combination of each state's Medicaid FFS, managed care, and eligibility improper payment rates. In addition, individual state improper payment rate components are combined to calculate the national improper payment rates for each component. National component improper payment rates and the Medicaid program improper payment rate are weighted by state size, so that a state with a \$10 billion program "counts" 10 times more toward the national rate than a state with a \$1 billion program. A small correction factor ensures that Medicaid eligibility improper payments do not get "double counted." Additionally, HHS incorporates state-level error rate recalculations for the states measured in FY 2013 and FY 2014 into the national Medicaid improper payment rate. Eight state-level FFS error rates were recalculated subsequent to FY 2014 reporting and are incorporated into FY 2015 improper payment rate reporting.

The national Medicaid gross improper payment estimate for FY 2015 is 9.78 percent or \$29.12 billion. The FY 2015 net improper payment estimate is 9.45 percent or \$28.13 billion. This rate increased from prior years due to an increase in the FFS component, as discussed in *Section 11.42*.

The FY 2015 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 10.59 percent
- *Medicaid managed care*: 0.12 percent

The Medicaid eligibility component improper payment rate is held constant at the FY 2014 reported rate of 3.11 percent.

#### ***Eligibility Pilot Review Findings***

The eligibility review pilots identified vulnerabilities in processes and systems that states took action to address, which is essential to preventing future improper payments. The most common issues identified through the eligibility review pilots were instances where caseworkers or systems did not properly establish household composition or income level, although these issues did not necessarily lead to eligibility determination errors. The pilots also provided states with essential feedback on their processes as states identified issues with improper requests for additional information from applicants, failure to send appropriate notices for denied cases, and failure to appropriately transfer denied cases to marketplaces. States are implementing corrective action strategies such as caseworker training and systems fixes as the pilots continue. More information on the pilots can be found at: [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014\\_FY2016EligibilityReviewPilots-.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html).

### **11.42 Medicaid CAPs**

States reviewed for the FY 2015 AFR measurement were the same states reviewed in FY 2012.

The improper payment rate for these states increased from 5.79 percent in FY 2012 to 14.25 percent in FY 2015, causing an increase in the FY 2015 national Medicaid error rate. The FFS component reported the greatest increase, rising from 3.34 percent to 18.63 percent. However, the managed care component dropped from 0.26 percent to 0.08 percent.

Similar to FY 2014, the primary reason for the FY 2015 improper payments was errors related to state difficulties bringing systems into compliance with new requirements for: (1) all referring or ordering providers to be enrolled in Medicaid, (2) states to screen providers under a risk-based screening process prior to enrollment, and (3) the inclusion of the attending provider National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen Medicaid's integrity, it is not unusual to see increases in improper payment rates following the implementation of new requirements because it takes time for states to make systems changes required for compliance.

HHS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. HHS received CAPs from all states with Medicaid programs that were previously measured, and all states measured in FY 2015 are developing CAPs for submission to HHS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. In addition, states also take steps to reduce errors identified during the measurement. HHS is actively engaging with states to proactively address these root causes by conducting outreach during off-cycle PERM time frames to address issues identified in CAPs, facilitating national best practice calls to share ideas across states, offering ongoing technical assistance, and providing additional guidance as needed.

### **Corrective Actions to Address Root Causes:**

#### ***Root Causes:***

#### ***1) Administrative or Process Errors Made by State or Local Agency***

Administrative or Process Errors Made by State or Local Agency mainly consist of errors caused by state difficulties bringing systems into compliance with new requirements as described above. Since the Medicaid improper payment rate was primarily driven by these errors, state CAPs will focus on systems changes to reduce these errors. Methods will include implementing new claims processing edits, converting to a more sophisticated claims

processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program.

### **2) Administrative or Process Errors Made by Other Party**

Administrative or Process Errors Made by Other Party mainly consist of provider billing and coding errors. State CAPs also include provider education, training, communication, and outreach efforts to help reduce these errors.

### **3) Insufficient Documentation to Determine**

Because insufficient documentation is another contributor to the Medicaid FFS improper payment rate, state CAPs have also focused on provider communication and education to reduce errors related to this category. These methods included holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written state policies emphasizing documentation requirements; and performing more provider audits to identify areas of vulnerability and target solutions.

In addition to the development, execution, and evaluation of the state-specific CAPs and the ongoing corrective actions reported on pages 177 – 178 of HHS’s FY 2014 AFR ([www.hhs.gov/afr/fy2014-other-information.pdf](http://www.hhs.gov/afr/fy2014-other-information.pdf)), HHS has implemented additional efforts to lower improper payments rates:

- HHS completed a “mini-PERM audit” in one state and continued a mini-PERM audit in two states. Mini-PERM audits are voluntary state-specific improper payment reviews, intended to assist states in identifying and eliminating improper payments during years states are not measured under PERM. These reviews assist states in developing targeted CAPs to decrease Medicaid improper payments.
- As of the end of FY 2015, 47 states and the District of Columbia had implemented Medicaid RAC programs to identify and recover overpayments and identify underpayments made for services in their Medicaid programs, but one of these states ended its RAC program when HHS approved an exception due to high managed care penetration. Four states currently have HHS-approved exceptions to Medicaid RAC implementation due to small beneficiary populations or high managed care penetration.
- HHS aligned state Program Integrity Reviews with off-cycle PERM reviews to maintain pressure on states to continuously correct errors.
- HHS allows states to rely on Medicare’s enrollment screening of providers to help prevent PERM-related enrollment errors. For example, state Medicaid agencies may rely on Medicare’s site visits, in specific circumstances where the provider is enrolled in Medicare and Medicaid.
- HHS shares Medicare data to assist states with meeting Medicaid screening and enrollment requirements.
- HHS provides ongoing education and outreach to states on federal requirements for Medicaid enrollment and screening.

## **11.43 Medicaid Program Improper Payment Recovery**

Through the PERM program, HHS identified \$152,967.74; \$618,550.41; and \$4,399,202.90 in Medicaid overpayments eligible for recovery for FYs 2013, 2014 and 2015, respectively. In addition, the amount of Medicaid overpayments eligible for recovery for FYs 2013 and 2014 was amended from information previously reported in HHS’s FY 2014 AFR to reflect changes made during state-level error rate recalculations.

HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed. Recoveries of Medicaid improper payments are governed by Section 1903(d)(2) of the *Social Security Act* and related regulations at 42 CFR Part 433, Subpart F under which states must return the federal share of overpayments. States reimburse HHS for the federal share of overpayments on the Medicaid CMS-64 expenditure report. Section 6506 of the *Affordable Care Act* amended Section 1903(d)(2) to allow states up to one

year from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment.

#### **11.44 Medicaid Information Systems and Other Infrastructure**

Since Medicaid payments occur at the state level, information systems and other infrastructure needed to reduce Medicaid improper payments would need to be implemented at the state level. In addition to errors caused by state systems non-compliance with new requirements, PERM faced many challenges with state payment systems that had paper only and aggregate claims, changes in information systems at the state level during the course of the measurement cycle, and a wide variation of system designs and capabilities. HHS has encouraged and supported states in their efforts to modernize and improve state Medicaid Management Information Systems (MMIS), which will produce greater efficiencies in the PERM measurement and strengthen program integrity. In addition, HHS has approved enhanced federal funding for nine states to implement predictive analytics technologies that are integrated with State MMIS. The state systems workgroup (composed of HHS and state staff representatives) meets regularly to identify and discuss system vulnerabilities and the impact on the measurement of improper payments.

HHS developed a comprehensive plan to modernize the federal Medicaid and CHIP data systems. The primary goal of this plan is to leverage technologies to create an authoritative and comprehensive Medicaid and CHIP data structure so that HHS can provide more effective oversight of its programs. The plan will also result in a reduction of state burden and the availability of more robust data for the PERM program.

HHS also developed the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will facilitate state submission of timely claims data to HHS, expand the MSIS dataset, and allow HHS to review the completeness and quality of state MSIS submittals in real-time. HHS will use this data for the Medicaid improper payment measurement and to satisfy other HHS requirements. Through the use of T-MSIS, HHS will not only acquire higher quality data, but will also reduce state data requests.

One state moved from MSIS to T-MSIS in FY 2015, and all remaining states will submit data in the T-MSIS file format in FY 2016.

#### **11.45 Medicaid Statutory or Regulatory Barriers that could limit Corrective Actions**

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

#### **11.46 Medicaid Program Best Practices**

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the states, HHS continues the pre-cycle phase of the PERM measurement. The pre-cycle phase occurs prior to a state's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the states.

In addition to the ongoing measures reported on page 179 of HHS's FY 2014 AFR ([www.hhs.gov/afr/fy2014-other-information.pdf](http://www.hhs.gov/afr/fy2014-other-information.pdf)). HHS continues to offer training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute (MII). Between FYs 2008 and 2015, the MII provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through 6,200 enrollments in 136 courses and nine workgroups at no cost to the states.



## 11.50 CHIP

### 11.51 CHIP Statistical Sampling Process

The national FY 2015 CHIP improper payment rate is based on measurements conducted in FYs 2013, 2014, and 2015. CHIP improper payments are estimated on a federal FY basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components. The eligibility component measurement is currently on hold as described in the eligibility component section below.

CHIP utilizes the same state sampling process as Medicaid. HHS determined that CHIP can be measured in the same states selected for Medicaid review each FY with a high probability that the CHIP improper payment rate will meet the IPIA required confidence and precision levels. Since CHIP and Medicaid will be measured in the same states each year, each state will be measured for CHIP once every three years. For information on how HHS grouped states into three cycles, refer to page 183 of HHS's FY 2012 AFR ([www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

#### ***FFS and Managed Care Component***

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. The FFS sample size was between 299 and 959 claims per state and the managed care sample size was between 68 and 300 payments per state. When a FFS component or managed care component for a state accounted for less than two percent of the state's total CHIP expenditures, the state's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred for claims in three states.

#### ***Eligibility Component***

In light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the *Affordable Care Act*, HHS will update the eligibility component measurement methodology and related PERM program regulation to reflect these changes. In August 2013 and October 2015, HHS released guidance announcing temporary changes to PERM eligibility reviews. For FYs 2015 through 2018, HHS will not conduct the eligibility measurement component of PERM. During this time, the national CHIP improper payment rate will be held constant at the FY 2014 reported rate of 4.22 percent.

In place of FYs 2015 through 2018 PERM eligibility reviews, all states are required to conduct eligibility review pilots. The eligibility review pilots provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors.

#### ***Calculations and Findings***

The national CHIP improper payment rate represents the combination of each state's FFS, managed care, and eligibility improper payment rates. In addition, individual state improper payment rate components are combined to calculate the national component improper payment rates. National component improper payment rates and the CHIP improper payment rate are weighted by state size, so that a state with a \$1 billion program "counts" 5 times more toward the national rate than a state with a \$200 million program. A small correction factor ensures that CHIP eligibility improper payments do not get "double counted." Additionally, HHS incorporates state-level error rate recalculations for the states measured in FY 2013 and FY 2014 into the national CHIP improper payment

rate. Seven state-level FFS error rates were recalculated subsequent to FY 2014 reporting and are incorporated into FY 2015 improper payment rate reporting.

The national CHIP gross improper payment estimate for FY 2015 is 6.80 percent or \$632.11 million. The FY 2015 net improper payment estimate is 6.68 percent or \$620.43 million. This rate increased from prior years due to an increase in the FFS component, as discussed in *Section 11.52*.

The FY 2015 national CHIP improper payment rate for each component is:

- *CHIP FFS* – 7.33 percent
- *CHIP managed care* – 0.37 percent

The CHIP eligibility component improper payment rate is held constant at the FY 2014 reported rate of 4.22 percent.

#### ***Eligibility Pilot Review Findings***

The eligibility review pilots identified vulnerabilities in processes and systems that states took action to address, which is essential to preventing future improper payments. The most common issues identified through the eligibility review pilots were instances where caseworkers or systems did not properly establish household composition or income level, although these issues did not necessarily lead to eligibility determination errors. The pilots also provided states with essential feedback on their processes as states identified issues with improper requests for additional information from applicants, failure to send appropriate notices for denied cases, and failure to appropriately transfer denied cases to marketplaces. States are implementing corrective action strategies such as caseworker training and systems fixes as the pilots continue. More information on the pilots can be found at: [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014\\_FY2016EligibilityReviewPilots-.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html).

### **11.52 CHIP CAPs**

States reviewed for the FY 2015 AFR measurement were the same states reviewed in FY 2012. The improper payment rate for these states increased from 8.16 percent in FY 2012 to 9.03 percent in FY 2015, causing an increase in the FY 2015 national CHIP error rate. The FFS component reported the greatest increase, rising from 6.93 percent to 13.13 percent.

Overall, the largest reason for the FY 2015 improper payments were errors related to state difficulties bringing systems into compliance with the new requirements described in the Medicaid section. While these requirements will ultimately strengthen the integrity of the program, it is not unusual to see increases in improper payment rates following the implementation of new requirements because it takes time for states to make systems changes required for compliance.

HHS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. HHS received CAPs from all states with CHIP programs that were previously measured, and all states measured in FY 2015 are developing CAPs for submission to HHS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. In addition, states also take steps to reduce errors identified during the measurement. HHS is actively engaging with states to proactively address these root causes through activities like: conducting outreach to states during off-cycle PERM time frames to follow-up on the status of state corrective actions for improvement with requirements, and to offer additional guidance as needed.

## Corrective Actions to Address Root Causes:

### *Root Causes:*

#### **1) Administrative or Process Errors Made by State or Local Agency**

Administrative or Process Errors Made by State or Local Agency mainly consist of errors caused by state difficulties bringing systems into compliance with new requirements as described above. Since the CHIP improper payment rate was primarily driven by these errors, state CAPs will focus on systems changes to reduce these errors. Methods include: implementing new claims processing edits, converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program.

#### **2) Administrative or Process Errors Made by Other Party**

Administrative or Process Errors Made by Other Party mainly consist of provider billing and coding errors. State CAPs also include provider education, training, communication, and outreach efforts to help reduce these errors.

#### **3) Insufficient Documentation to Determine**

Because insufficient documentation is also a contributor to the CHIP improper payment rate, the state CAPs also focused on strengthening provider communication and education to reduce errors related to these categories. These methods included enhancing provider training, presentations, newsletters, notices, bulletins, and provider broadcasts; conducting outreach to public providers; and performing more provider audits to identify areas of vulnerability and target solutions.

In addition to the development, execution, and evaluation of the state-specific CAPs and the ongoing corrective actions reported on page 181 of HHS's FY 2014 AFR ([www.hhs.gov/afr/fy2014-other-information.pdf](http://www.hhs.gov/afr/fy2014-other-information.pdf)), HHS has implemented additional efforts to lower improper payment rates:

- HHS completed a “mini-PERM audit” with three states. Mini-PERM audits are voluntary, state-specific improper payment reviews, intended to assist states in identifying and eliminating improper payments during years states are not measured under PERM. These reviews assist states in developing targeted CAPs to decrease CHIP improper payments.
- HHS allows states to rely on Medicare’s enrollment screening of providers to help prevent PERM-related enrollment errors.
- HHS shares Medicare data to assist states with meeting screening and enrollment requirements.
- HHS provides ongoing education and outreach to states on federal requirements for enrollment and screening.

## 11.53 CHIP Program Improper Payment Recovery

HHS identified \$161,763.63; \$688,941.56; and \$1,909,778.03 in CHIP overpayments eligible for recovery for FYs 2013, 2014, and 2015 respectively. In addition, the amount of CHIP overpayments eligible for recovery for FYs 2013 and 2014 was amended from information previously reported in HHS's FY 2014 AFR to reflect changes made during state-level error rate recalculations.

HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed. Recoveries of CHIP improper payments are governed by 2105(c)(6)(B) and Section 2105(e) of the *Social Security Act* and related regulations at 42 CFR Part 457, Subpart B under which states must return the federal share of overpayments. States reimburse HHS for the federal share on the CHIP CMS-21 expenditure report. Section 6506 of the *Affordable Care Act* amended Section 1903(d)(2) to allow states up to one year from the date of discovery of an overpayment for services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment.

### 11.54 CHIP Information Systems and Other Infrastructure

Since CHIP payments occur at the state level, information systems and other infrastructure needed to reduce CHIP improper payments would need to be implemented at the state level. Please refer to *Section 11.44: Medicaid Information Systems and Other Infrastructure* for information on HHS and state-led efforts to modernize information and data systems at the national and state level.

### 11.55 CHIP Statutory or Regulatory Barriers that Could Limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 11.56 CHIP Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the states, HHS continues the pre-cycle phase of the PERM measurement. The pre-cycle phase occurs prior to a state's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the states. In addition, other ongoing measures are reported on page 182 of HHS's FY 2014 AFR ([www.hhs.gov/afr/fy2014-other-information.pdf](http://www.hhs.gov/afr/fy2014-other-information.pdf)).

### 11.60 TANF

#### 11.61 TANF Statistical Sampling Process

Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an error rate for FY 2015. In the meantime, the Department is engaging with OMB to explore potential options to develop an alternative approach that could bring TANF into compliance with the law and reporting requirements.

#### 11.62 TANF CAPs

Due to TANF being a state-administered program, corrective actions that could help reduce improper payments would have to be implemented at the state level. The TANF statute prohibits HHS from requiring state TANF agencies to implement and report on corrective actions. Despite the limitations, HHS has taken the following actions to assist states in reducing improper payments:

- HHS works with states to analyze Single Audit material non-compliance findings related to TANF and to implement corrective actions to address these findings.
- HHS performed a detailed risk assessment of the TANF program. As part of this process, HHS identified potential programmatic risks at the federal level and is working to mitigate these programmatic risks.
- HHS monitors a TANF Program Integrity Innovation Grant funded from OMB's Partnership Fund for Program Integrity Innovation. The state human service agency grantee is conducting a pilot project designed to reduce improper payments and improve administrative efficiency in the state's TANF program. The grant is scheduled to end in November 2015 and the final report will be issued in early 2016. This report will include lessons learned and valuable information for developing guidance that will improve TANF program integrity in other states.
- HHS implemented revisions to the TANF financial reporting form in order to require states to provide more accurate information about how states are using TANF block grants and meeting their Maintenance-of-Effort obligations. The changes took effect in FY 2015, and include a revised and expanded list of

spending categories as well as a change to the accounting method to accurately track actual expenditures that occur in a FY.

- In February 2014, HHS published a Notice of Proposed Rulemaking regarding “State Reporting on Policies and Practices to Prevent the Use of TANF Funds in Electronic Benefit Transfer Transactions in Specified Locations.” The proposed regulations would require states, subject to penalty, to maintain policies and practices that prevent TANF funded assistance from being used in any electronic benefit transfer transaction in specified locations. The locations, specified in the *Middle Class Tax Relief and Job Creation Act of 2012*, are: liquor stores; any casino, gambling casino, or gaming establishment; and any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment. HHS anticipates that the final regulation will be published in the last quarter of calendar year 2015.

### **11.63 TANF Improper Payments Recovery**

Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. As a result, HHS is not reporting an error rate or any results from improper payment recoveries for FY 2015.

### **11.64 TANF Information Systems and Other Infrastructure**

Information systems and other infrastructure needed to reduce TANF improper payments would need to be implemented at the state level. States utilize PARIS, the National Directory of New Hires (NDNH), and the Income and Eligibility Verification System (IEVS) to minimize improper payments. No other systems or infrastructure are needed at this time.

### **11.65 TANF Statutory or Regulatory Barriers**

Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement.

### **11.66 TANF Program Best Practices**

HHS encourages states to stress the importance of payment accuracy for TANF cases and seriously consider measures that will reduce erroneous payments. Those actions may include, but are not limited to:

- Conduct local office quality control reviews for eligibility and payment processes at both the initial intake and redetermination stages of the case, and perform periodic “checks” of case records, paying particular attention to documentation such as a current application and facts supporting income, household composition, participation in work activities, and cooperation with child support enforcement.
- Develop and maintain a reminder system for critical follow-up actions on cases such as responding to reports of non-cooperation with child support, IEVS “hits,” eligibility redeterminations, or failure to fulfill work requirements.
- Remind TANF recipients periodically of their responsibility to accurately report income, resources, and other changes in family circumstances to the local TANF agency on a timely basis.
- Use NDNH information to verify the eligibility of adult TANF recipients residing in the state; and to modify benefits or close the case if the individual is not eligible for assistance.
- Conduct training on investigative interviewing techniques for intake workers and case managers.
- Establish and monitor internal procedures to ensure that TANF payments are adjusted on a timely basis when family circumstances change and affect case eligibility or the amount of payment, and establish a process for the collection of TANF overpayments from the applicable recipients.

## 11.70 Foster Care

### 11.71 Foster Care Statistical Sampling Process

There were no changes to the statistical sampling process for Title IV-E Foster Care in FY 2015, but as described below, there were changes to the number of states reviewed. Because current regulations require that programs be reviewed every three years for compliance, this program has taken the review cycle already in place (in compliance with 45 CFR 1356.71, Foster Care Eligibility Reviews) and, with OMB approval, leveraged the existing review cycle to provide a rolling three-year average improper payment rate. Under this approved approach, the Foster Care improper payment estimate is calculated each year using data collected in the most recent Foster Care Eligibility Review for each state. A random sample is drawn from the state's universe of cases having at least one Title IV-E Foster Care maintenance payment during the six-month period under review (PUR). A review of the sample items identifies the number of error cases and amount of payment errors. Since each state is reviewed every three years, each year's data incorporates new review data for about one-third of the states. For a more detailed description of the Foster Care improper payments statistical sampling and estimation methodology, refer to pages 189 - 190 of HHS's FY 2012 AFR ([www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

However, an increasing number of time-limited demonstration projects will temporarily reduce the number of jurisdictions subject to review and inclusion in the program error rate estimate for the duration of the demonstration projects. These child welfare waiver demonstration projects, authorized by Section 1130 of the *Social Security Act*, waive many program eligibility requirements and allow flexible use of Title IV-E funds to encourage innovative practices and improved child and family outcomes, while ensuring federal cost-neutrality. The authorizing law (section 1130(d)(2)) requires that all demonstration projects be completed by September 30, 2019. Because the demonstration waiver terms and conditions explicitly permit states to use Title IV-E funds for purposes, populations, and activities not normally allowed to be claimed as Title IV-E Foster Care maintenance or administration, states with statewide demonstration waivers will not be subject to Title IV-E eligibility reviews for the duration of the implementation of their demonstration projects. States with non-statewide demonstration projects will continue to undergo Title IV-E eligibility reviews; these reviews will examine data for that part of each state (i.e., geographic areas or populations) continuing to operate as a traditional IV-E program. States not participating in waiver demonstrations will also continue to undergo Title IV-E eligibility reviews on the regular three-year cycle.

Given the temporary nature of the waiver demonstrations and in the interest of maintaining a program estimate that is consistent not only with previously reported improper payment estimates but also across statewide and non-statewide waivers, HHS will treat jurisdictions with operational waivers as it has in the past:

- The program error rate estimate will include data from the most recent review for states with statewide waivers until the year when each state would normally have been reviewed again and when its data would normally be replaced with data from a new review (i.e., within three years and three months).
- The program error rate estimate will include data from the most recent review for states with non-statewide waivers, including subsequent reviews conducted on the non-waiver populations in those states following waiver implementation. The state error rate is based on review data for a sample receiving traditional Title IV-E services, and the sample rate is applied to overall state payments for those traditional IV-E services (i.e., excluding payments for the counties or other populations participating in demonstration projects).

This approach, which was approved by OMB, maintains continuity in the error rate while permitting consistent treatment of states with statewide and non-statewide waivers. Following this approach, the FY 2015 estimate is based on review data for 49 states operating traditional Title IV-E programs.<sup>25</sup>

The Foster Care gross improper payment estimate for FY 2015 is 3.65 percent or \$30.68 million. The FY 2015 net improper payment rate is 3.06 percent or \$25.72 million. The primary factor that drove the program's decrease from the prior year's estimate was the improved performance of one very large state that was reviewed in this cycle. This state lowered its state-level error rate from 22.15 percent, the highest rate of any state, to 3.43 percent.

## 11.72 Foster Care CAPs

All payment errors (100 percent) in the Title IV-E Foster Care Program are Administrative or Process Errors due to incorrect case classification and payment processing by state agencies. The Foster Care program designs CAPs to help states address these payment errors that contribute most to Title IV-E improper payments.

### Corrective Actions to Address Root Cause:

#### **Root Cause: Administrative or Process Error Made by State or Local Agency**

Corrective actions have decreased the overall number of payment errors and altered the composition of identified payment errors. For example, following years of work with State Court Improvement Programs and outreach to heighten judicial awareness, judiciary-related errors, once the most prevalent error type, are now among the least common.

HHS continues to monitor review results and analyze the types of payment errors in the Foster Care program to target corrective action planning. In FY 2015, the most common payment errors included:

- Underpayments (28 percent of errors),
- Provider not licensed or approved (10 percent of errors),
- No safety documentation for institutional caregiver staff (10 percent of errors),
- Provider criminal records check not completed (9 percent of errors),
- Family not eligible for the Aid to Families with Dependent Children program at time of removal (7 percent of errors), and
- Reasonable efforts to finalize permanency plan not timely (6 percent of errors).

Together these six items account for 70 percent of Foster Care payment errors. Although underpayments represent just over one-quarter of all errors in terms of frequency, the dollar amount of the underpayments is quite small and, in fact, continued to decrease in 2015 as the underpayment rate improved from 0.31 percent in FY 2014 to 0.30 percent in FY 2015.

In FY 2015, HHS undertook the following key action to reduce improper payments:

- Based on discussions with individual states on review preparation and compliance results, HHS worked with states to emphasize and develop strategies for continuous program improvement with an emphasis on: viewing the quality assurance process as an ongoing, systematic process that is not limited to review preparations or results; and developing sound program improvements that support systemic change and sustain the improvement effort.

<sup>25</sup> The FY 2015 estimate excludes data for three states that were due for a review but are operating statewide demonstration waivers: Florida, Utah, and Wisconsin.



In addition, HHS continued the following ongoing corrective actions:

- HHS conducts onsite and post-site review activities to validate the accuracy of state claims for reimbursement of payments made on behalf of children and their Foster Care providers. Specific feedback is provided onsite to the state agency to positively affect proper and efficient program administration and implementation. Furthermore, HHS issues a comprehensive final report that presents findings of the review to the state agency. The final report serves as the basis for the development of a Program Improvement Plan (PIP) for states that exceed the error threshold.
- HHS requires non-compliant states (those that exceed the error threshold) to develop and execute state-specific PIPs that link corrective actions to the root cause of payment errors. The PIP identifies the specific action steps necessary to target and correct error root causes, and each action strategy is required to have a projected completion within one year from the date HHS approved the plan. PIPs are an effective strategy, as reflected in the decrease of the national Title IV-E error rate by nearly two-thirds since FY 2004.
- HHS provides training and technical assistance to states to develop and implement program improvement strategies, even when states are not required to develop a PIP. This assistance helps states expand organizational capacity and promote more effective program operations.
- HHS conducts secondary reviews, as applicable, and takes appropriate disallowances consistent with the review findings, including an extrapolated disallowance if the state is found not in substantial compliance. These additional disallowances, in conjunction with the development and implementation of the PIP, serve as a strong incentive to states to improve compliance.

### **11.73 Foster Care Improper Payment Recovery**

As a result of conducting Foster Care eligibility reviews in 12 states during the 12-month period between July 2014 and June 2015, HHS recovered nearly \$1 million in Title IV-E improper payments. The recovered funds are comprised of \$569,458 in disallowed maintenance payments and \$421,329 in disallowed administrative payments.

Improper payment recovery occurs through post-payment review, through both eligibility reviews as well as audit reviews. The Foster Care program does not systematically track cost recovery through Office of Inspector General (OIG) reviews or Single Audit reports; rather, the program obtains this information from HHS reports generated as part of the audit clearance process. Specifically, the program identifies and tabulates audit findings where the audit has been closed and a recommended cost recovery has been sustained for the Title IV-E Foster Care program. These recovery amounts are in addition to the amounts identified through the eligibility reviews and are presumed to be recovered in the FY when the audit is closed. Recoveries of improper payments through audits may include Title IV-E Foster Care maintenance assistance payments, administration, training, and automated systems development costs. See *Section 13.0* for further information on payment recovery.

### **11.74 Foster Care Information Systems and Other Infrastructure**

HHS uses the Adoption and Foster Care Analysis and Reporting System to draw samples for the regulatory reviews. Utilization of this system reduces the burden on states to draw their own samples, promotes uniformity in sample selection, and employs the database in a practical and beneficial manner. Since Foster Care payments occur at the state level, information systems and other infrastructure needed to reduce Foster Care improper payments would need to be implemented at the state level. No other systems or infrastructure are needed at this time.

### **11.75 Foster Care Statutory or Regulatory Barriers**

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.



### 11.76 Foster Care Best Practices

Since the inception of its improper payment reporting, HHS has maintained a diligent focus on improper payment identification and reduction efforts in the Foster Care program. Refinements to the error rate methodology have included steps to ensure systematic examination and consideration of underpayments in eligibility reviews and modifying data retention practices to permit shifting from case-based extrapolation to dollar-based extrapolation.

Concurrent with these efforts to continually refine its identification and reporting of improper payments, HHS works with state child welfare agencies to improve administrative procedures for tracking and documenting eligibility. As a result, a number of states have developed knowledgeable and experienced eligibility teams that monitor foster care cases for changes in eligibility, work effectively with front-line staff, and identify emerging issues and trends to maintain strong performance. HHS also works with the judiciary to support adherence to requirements for timely and thoroughly documented case hearings and court orders. These efforts have yielded reductions in eligibility errors and improper payments, as well as the recovery of \$20.35 million in improper payments for the FY 2004 through FY 2015 reporting periods.

### 11.80 CCDF

#### 11.81 CCDF Statistical Sampling Process

The methodology for measuring improper payments uses a case-record review process to determine if child care subsidies were properly paid for services provided to eligible families. The methodology focuses on improper payments made, and enables states to determine the types of errors and their sources. For the CCDF improper payments methodology, please see [www.acf.hhs.gov/programs/occ/resource/program-integrity-and-accountability-improper-payments-error-rate-review](http://www.acf.hhs.gov/programs/occ/resource/program-integrity-and-accountability-improper-payments-error-rate-review).

The current methodology incorporates the following: (a) drawing a statistical sample from a universe of paid cases, (b) measuring improper payments, and (c) requiring states with error rates exceeding 10 percent to submit a CAP. The error rate methodology and reporting requirements focus on administrative errors associated with client eligibility. The CCDF gross improper payment estimate for FY 2015 is 5.74 percent or \$311.13 million. The FY 2015 net improper payment estimate is 4.77 percent or \$258.65 million. There were several contributing factors to the slight increase in the improper payment rate from 5.7 percent in FY 2014, which are more fully explained in the root causes section that follows. The reporting cohort for FY 2015—referred to as Year Two States—also has historically higher error rates than the prior reporting cohort. Since the methodology is a rolling three-year cycle, FY 2015 is only updating one-third of the data.

#### 11.82 CCDF CAPs

Administrative or process errors represent approximately 80.6 percent of errors found in the reviews. These errors consist of the failure to apply policy correctly, including:

- Income calculation (10 states),
- Units of care authorized (4 states),
- Parent fee calculation (4 states), and
- Change reports (i.e., when eligibility staff update case records in response to family status changes) (4 states).

Insufficient Documentation errors account for an estimated 19.4 percent of errors identified in the CCDF improper payment review process. Errors were primarily due to missing or insufficient documentation in the case record. The most frequently cited errors due to missing or insufficient documentation include:

- Paystubs or income verification (5 states),
- Need for care (such as work or school schedules) (4 states),
- Birth certificates or other documentation (3 states), and
- Application or redetermination forms (3 states).

### **Corrective Actions to Address Root Causes:**

#### ***Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by or Local Agency***

HHS and states have established corrective actions targeting both error types. States reporting in FY 2015 plan the following actions:

Year Two States, as described in *Section 11.83*, identified the following implementation actions to correct improper payment error causes:

- Ongoing case reviews or audits,
- Trainings with eligibility staff on CCDF policies and procedures,
- Upgraded or enhanced information technology (IT) systems,
- Changes or update to state eligibility policies and procedures,
- Ongoing technical assistance to eligibility staff to address specific causes of errors, and
- One-on-one trainings with eligibility staff in response to audit findings.

HHS's corrective actions have been consistent over time and assist states in reducing error rates. In addition to this ongoing work, the FY 2015 corrective actions include the following activities:

- Conduct remote or onsite joint case reviews to ensure implementation of the HHS approved state review tools (6 states),
- Conduct site visits with states needing assistance to address root causes of errors (3 states),
- Provide technical assistance to states around policy and procedure changes to meet new requirements under the *Child Care and Development Block Grant Act of 2014 (CCDBG Act)* (all states),
- Deliver technical assistance to states regarding updating or developing IT systems that will improve practices and reduce errors (10 states), and
- Provide individual reporting cohort training on the methodology that allows states to learn best practices from each other as they conduct the reviews (34 states).

### **11.83 CCDF Improper Payment Recovery**

Under the current methodology, grantees provide information on both the estimate they expect to recover from the current review and any funds recovered from prior reviews. CCDF regulations only require states to recover misspent funds due to fraud. States have discretion whether to recover misspent funds for other reasons. All misspent funds are subject to disallowance.

The cumulative FY 2015 CCDF improper overpayment amount is \$346,186. The overall improper payment estimate is comprised of three review periods: FYs 2013, 2014, and 2015. The improper payments are as follows for each period:

- Year One States (reported in FY 2014) - \$50,736,
- Year Two States (reported in FY 2015) - \$93,153, and
- Year Three States (reported in FY 2013) - \$202,297.

The FY 2015 review cycle represents the third time that Year Two States have conducted the error rate measurement. In FY 2012, the last time this cycle of states was measured, the states reported an improper over authorization amount of \$146,914, and they anticipated and realized a recovery of approximately 18 percent, or \$26,896, of this total. Year Two States reported improper payments of \$93,153 in FY 2015, and anticipate recovering 29 percent, or \$27,144, of these payments. Reports submitted in FY 2018 will address any amounts recovered based on the FY 2015 reviews.

### 11.84 CCDF Information Systems and Other Infrastructure

Since CCDF payments occur at the state level, information systems and other infrastructure needed to reduce CCDF improper payments would need to be implemented at the state level. In addition to the efforts outlined in prior HHS AFRs, states reported a range of other improvements to information systems including steps to:

- *Increase access to client information:* including data synced with other assistance programs, quality control case reviews or reports, and system flags and blocks to avoid duplication or errors.
- *Increase access to provider information:* including automated billing reports, payment management tracking, provider licensing information, and automated payment rate determination.
- *Assist with eligibility determinations:* including access to data in other assistance programs' systems to obtain or confirm eligibility information, increased automation of eligibility processes, system flags, and blocks to avoid errors, automated copay calculation, and document storage.

### 11.85 CCDF Statutory or Regulatory Barriers

No statutory or regulatory barriers that would limit corrective actions have been identified at this time.

The *CCDBG Act*, signed into law in November 2014, reauthorized CCDF for the first time since 1996. The statute improves the quality and access to care for children across the country by requiring states to change eligibility to a minimum of 12 months, revise redetermination policies, update provider payment rates and payment practices, and increase health and safety standards for providers. States will be required to create new policies and procedures to enact the requirements of the law, which will likely increase errors as the changes are implemented. The improper payment targets identified in Table 1A reflect the anticipated brief rise in errors while states adjust to the changes.

### 11.86 CCDF Best Practices

In addition to those best practices cited in prior reports, Year Two States also reported:

- *Trainings for review staff:* trainings helped review staff to be well informed of CCDF policy and practices, error definitions, and the process for reviewing and documenting errors.

- *Coordination between review staff and child care policy staff:* ongoing communication and coordination between reviewers and CCDF staff (sometimes located in different departments or agencies) was useful during this review cycle.
- *Timely review process:* for example, starting early or conducting real time reviews.
- *Staffing changes:* expanding the review team or reassigning personnel to certain tasks improved the review process.
- *Updated eligibility systems:* new or upgraded IT systems made it easier to select cases and gather information for reviewers.
- *HHS webinars:* attendance at HHS webinars helped states successfully complete the reviews and required submissions.

HHS best practices included:

- Targeted technical assistance for methodology implementation.
- Group and individual technical assistance for peer-to-peer sharing of review findings and best practices to improve the reviews.
- Technical assistance to states around policy and procedure review and revision to address changes under the new CCDBG law.

## 12.0 Internal Control Over Payments

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Appendix C to OMB Circular A-123, which was updated and released in October 2014, established the requirement that agencies with programs susceptible to significant improper payments and that are reporting improper payment estimates summarize the status of their internal control processes. The establishment of a robust internal control system can prevent and detect improper payments, and recover any improper payments that were made. The following tables display HHS's status of internal control over payments for the high-risk programs that report annual error rate estimates. The tables include an assessment of the status of internal control over payments against five internal control standards for each program.

**Table 3A**  
**FY 2015 Medicare Status of Internal Controls**

Internal Control Standards	Medicare FFS	Medicare Part C	Medicare Part D
Control Environment	4	4	4
Risk Assessment	4	4	4
Control Activities	3	3	3
Information and Communication	4	4	4
Monitoring	3	3	3

**Legend:**

- 4 = Sufficient controls are in place to prevent Improper Payments (IPs)
- 3= Controls are in place to prevent IPs but there is room for improvement
- 2 = Minimal controls are in place to prevent IPs
- 1= Controls are not in place to prevent IPs

HHS continues to improve and evaluate its internal control activities in the programs susceptible to significant improper payments. A summary of the efforts by program are described below.

Generally, as described below, the Medicare FFS, Medicare Part C, and Medicare Part D programs have adequate controls in place to prevent improper payments. HHS's reporting and analyses of improper payments to determine the nature, extent, magnitude, and root cause(s) of improper payments has led to the implementation of several strategies to identify and reduce such payments and strengthened the control environment. HHS has implemented effective control activities to prevent improper payments in the Medicare programs—preventive controls—and identify payments after the payments are made—detective controls. The kinds of key control activities in place to prevent improper payments include:

- MACs administer the Medicare program and HHS provides numerous guidelines and policies to the contractors to ensure effectiveness and efficiency. In particular, HHS requires that the MACs comply with Chapter 7 – Internal Control Requirements of the Medicare Financial Management Manual that outlines the Control Objectives (including processes such as Information Systems, Claims Processing, Medical Review, Provider Audit and Provider Enrollment) that contractors must follow to assist them in maintaining and strengthening their internal control procedures.
- HHS follows a strict review and approval process before processing Medicare claims, both manual and automated. The Medicare claims processing systems track each claim from receipt to final resolution. The systems check each claim, adjustment, and any other transaction for validity and, in accordance with HHS instructions, rejects such claims, adjustment, or other transaction failing such validity check. Each claim is adjudicated in accordance with HHS instructions.
- HHS has developed prior authorization demonstrations for items and services that historically experience high incidences of improper payments, such as PMDs, to ensure that services are provided in compliance with applicable Medicare coverage, coding, and payment rules before the services are rendered and claims are paid.
- HHS follows a strict review and approval process before issuing Medicare Part C and Part D payments. HHS Plan Payment Validation (PPV) activities are conducted each month to validate payments to MA plans, prescription drug plans, Programs of All-Inclusive Care for the Elderly (PACE), certain demonstrations and cost plans.

- HHS independently recalculates payments using data from source systems. Analysis is performed to further validate the accurate application of correct input data for payment calculations.
- HHS uses the NCCI to stop claims that never should be paid, such as a hysterectomy for a man or a prostate exam for a woman.

The kinds of key control activities in place to identify improper payments after the payments are made include:

- For the Medicare FFS program, MACs are responsible for identifying improper payments and adjusting benefit payments as appropriate. HHS regulations require timely and aggressive efforts to collect overpayments which include locating the debtor, demanding repayment, initiating benefit offset, establishing repayment schedules and referral to Treasury for cross servicing via the Treasury Offset Program (TOP).
- HHS utilizes various types of contractors including MACs, RACs, SMRC, and CERT contractors to identify and correct Medicare improper payments and promote provider compliance in the Medicare program. These contractors conduct post payment medical reviews focused on the agency's improper payment vulnerabilities to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements.
- HHS conducts certification of PDE and risk adjustment data for payment on an annual basis after the end of each coverage year. In their attestations, MA organizations and Part D sponsors attest to the accuracy, completeness, and truthfulness of the information submitted to HHS and acknowledge that PDE and risk adjustment data directly affects the calculation of their payments and that misrepresentation to HHS may result in federal civil action and/or criminal prosecution.
- HHS performs various financial reviews for the Part C and D programs to ensure the validity of payments made and to calculate risk sharing. These include but are not limited to the following: (1) monthly reconciliations as part of the plan validation process; (2) risk adjustment reconciliation in which HHS calculates final risk adjustment factors for the year based on newly submitted diagnostic data and any changes in enrollment, long-term institutional and low-income subsidy status; and (3) plan-to-plan (P2P) reconciliation that ensure accurate payments to and by plans.

The Medicare program also has various techniques in place to use, share, and communicate information to prevent improper payments and ensure the information is timely, accurate, and reliable. The source of information, method of distribution, and type of communication can vary widely and includes:

- Each year, HHS establishes program policies, leads special initiatives, oversees compliance, and establishes performance monitoring practices, which are then carried out by the Regional Offices.
- HHS publishes articles in the Medicare Learning Network Medicare Quarterly Provider Compliance Newsletter. The articles discuss documentation requirements, CERT findings, and common errors.
- Similar to the CBRs, HHS continues to develop and issue Program for Evaluating Payment Patterns Electronic Report (PEPPER) to support hospitals or facilities compliance efforts by identifying where its billing patterns are different from the majority of other providers in the nation.
- HHS has contracted with program integrity contractors known as MEDICs, which primarily assist in outreach, education, data analysis, and case referrals to law enforcement.
- MA Organizations (MAOs) receive regular payment reports to review against their records. These reports inform the MAO of the payments made for the beneficiaries and/or underlying data which is used by the MARx payment system to make payments. It includes information on enrollment and enrollee risk scores used for payment.
- PDE Reports, which provides Part D sponsors with reports on the quality, timeliness, and accuracy of PDE data and error resolution efforts.

- PDE Analysis initiative, which addresses data quality issues on accepted PDE records in advance of the Part D payment reconciliation. PDEs are posted for Part D sponsor review and action, which may include (1) providing a written response with an explanation if the PDE data are valid, or (2) adjusting or deleting the PDE accordingly if the PDE data are invalid.

The Medicare program also conducts a variety of monitoring and assessment activities such as:

- In reference to Chapter 7 – Internal Control Requirements mentioned above - HHS conducts various reviews and attestations to ensure that Medicare contractors are complying with internal control requirements. First, each Medicare contractor provides assurance that internal controls are in place via their Certification Package for Internal Controls (CPIC). The CPIC includes a self-certification representation that the contractor's internal controls are in compliance with *Federal Managers' Financial Integrity Act of 1982* (FMFIA) expectations. Second, each Medicare contractor will engage an independent public accounting firm who will conduct an assessment of the contractor's internal controls in accordance with Statement on Standards for Attestation Engagements (SSAE) No. 16 Reporting on Controls at a Service Organization. This 'audit' in addition to other internal control reviews conducted on the contractor, ensures that internal controls are in place and operating effectively.
- HHS performs contractor oversight such as providing broad direction on medical review policy and annual medical review strategies; facilitating compliance with legislation and regulations; conducting continuous monitoring and evaluation of Medicare contractors' performance; and providing feedback to contractors regarding the Medicare program and medical review issues.
- HHS monitors the MAC performance in recovering overpayments and in documenting and reporting these recovery efforts, as detailed in the Medicare Financial Management Manual.
- HHS conducts a comprehensive MA Oversight Program that is fueled by data provided by the Plan Sponsors and beneficiaries. The goals of HHS's oversight strategy are to identify MA program vulnerabilities, assure strict adherence to MA regulatory and program requirements, and detect and prevent fraud, waste, and abuse. HHS also has a similar Part D oversight program.

HHS continues to improve and evaluate its internal control activities in the Medicare FFS, Medicare Part C, and Medicare Part D programs to prevent improper payments.

**Table 3B**  
**FY 2015 Medicaid and CHIP Status of Internal Controls**

Internal Control Standards	Medicaid	CHIP
Control Environment	3	3
Risk Assessment	4	4
Control Activities	3	3
Information and Communication	3	3
Monitoring	3	3

**Legend:**

- 4 = Sufficient controls are in place to prevent IPs
- 3= Controls are in place to prevent IPs but there is room for improvement
- 2 = Minimal controls are in place to prevent IPs
- 1= Controls are not in place to prevent IPs

Since Medicaid and CHIP are state-administered programs, both HHS and states are responsible for ensuring appropriate payments in the Medicaid and CHIP programs. Generally, as described below, the Medicaid and CHIP programs have adequate controls in place to prevent improper payments. HHS's reporting and analyses of improper Medicaid and CHIP payments to determine the nature, extent, magnitude, and root cause(s) of improper payments has led to the implementation of several strategies to identify and reduce such payments and strengthened the control environment. HHS has implemented control activities to prevent improper payments in the Medicaid and CHIP programs—preventive controls—and identify payments after the payments are made—detective controls. The kinds of key control activities in place at HHS to prevent improper payments include:

- The Medicaid State Plan is the official Medicaid program contract between a state and HHS and is used to establish and determine what benefits or services are covered, who is eligible for those benefits, and how services are paid. Changes to the Medicaid State Plan are proposed by states through State Plan Amendments (SPAs) and are reviewed and approved by HHS. States are not allowed to claim federal-matching funds based upon a SPA until HHS approval.
- On an annual basis, the Federal Medical Assistance Percentage (FMAP) for each state is obtained from the Federal Register and hard coded into a web-based system to be used on the State's Quarterly Expense Report to ensure accuracy and prevent overpayment to the states.
- HHS follows a strict review and approval process before issuing quarterly grant awards to states. The states will submit a Medicaid Program Budget Report to HHS that provides a statement of the state's Medicaid funding requirements for a certified quarter and estimates for two FYs, and the state must certify that the requisite matching state and local funds are, or will be, available for the certified quarter. Similarly for CHIP funding, the states will submit a CHIP Program Budget Report. HHS uses the information to prepare the grant awards to states to ensure that the appropriate level of federal payments for state expenditures are made in accordance with the CHIP legislative provisions and to monitor and evaluate the number of children served by the Medicaid and CHIP programs.
- The HHS Payment Management System (PMS) is responsible for processing Medicaid payments to states. HHS relies on financial information provided by PMS to account for the payments to states for the Medicaid program. HHS developed internal controls to ensure that the financial data as provided by PMS is accurately and completely reflected in HHS's financial records.
- States are responsible for determining eligibility, enrolling providers and beneficiaries, setting payment rates, contracting with plans, adjudicating claims, and claiming expenditures. States are also responsible



for ensuring that Medicaid and CHIP program operations, including those relating to provider payments, are consistent with the *Social Security Act* and implementing regulations.

The kinds of control activities in place to identify improper payments after the payments are made include:

- States are required to submit a summary of actual expenditures derived from source documents including payment vouchers, cost reports, and eligibility records. This information will inform HHS on the disposition of Medicaid grant funds for the quarter and any prior period adjustments. It also accounts for any overpayments, underpayments, refunds received by state Medicaid agencies, and income earned on grant funds. HHS conducts a thorough review and approval process of this information.
- HHS will issue state disallowances or deferrals as a result of audits or quarterly reviews.
- HHS implemented the Comprehensive Medicaid Integrity Program to reduce improper payments by utilizing contractors to review provider activities, audit claims, identify overpayments, and conduct provider education; and provide effective support and assistance to the states in their efforts to combat provider fraud and abuse.
- HHS operates the PERM program to identify Medicaid and CHIP improper payments that do not meet all state, Medicaid and CHIP coverage, coding, and medical necessity requirements.
- States are responsible for determining eligibility, enrolling beneficiaries, and adjudicating claims. Additionally, states are required to operate a Medicaid fraud and abuse control unit that is separate from the state Medicaid agency unless the state demonstrates that there is minimal fraud in its Medicaid program and that beneficiaries will be protected from abuse and neglect.

The Medicaid and CHIP programs also have various techniques in place to use, share, and communicate information to prevent improper payments and ensure the information is timely, accurate, and reliable. The source of information, method of distribution, and type of communication can vary widely and includes:

- Each quarter, HHS prepares and issues guidelines and instructions for the preparation of the Quarterly Medicaid Program Budget Report, which states use to provide a statement of the states' Medicaid funding requirements for a quarter and estimates underlying assumptions for the current FY. The data in the Medicaid Program Budget Report provides a variety of information that is essential to HHS in determining historical expenditure and estimating trends, and in developing federal Medicaid regulations, policy, and budgets.
- HHS senior officials are briefed monthly on the status of and issues resulting from review of state financial management reviews; including monetary and non-monetary findings, for program compliance and status of progress toward resolution.

The Medicaid and CHIP programs also conduct a variety of monitoring and assessment activities such as:

- HHS performs various financial reviews for the Medicaid program, including quarterly reviews of the states' submissions of budget and expenditure reports and focused financial management reviews, which are used to perform in-depth and focused analysis of a specific area of a state's Medicaid program.
- HHS operates the PERM program to identify Medicaid and CHIP improper payments. States are required to develop CAPs to address errors identified in the PERM measurements.
- HHS performs audit resolution and reviews audit findings to ensure they conform to existing Medicaid and CHIP regulations and policies. Following these efforts, HHS initiates the collection of monies due and/or negotiates an agreed upon course of corrective action with the state.

**Table 3C**  
**FY 2015 Foster Care and Child Care Status of Internal Controls**

Internal Control Standards	Foster Care	Child Care
Control Environment	3	3
Risk Assessment	4	3
Control Activities	4	3
Information and Communication	4	3
Monitoring	4	3

Note: TANF is not included in this section since HHS is not reporting an improper payment estimate.

**Legend:**

4 = Sufficient controls are in place to prevent IPs

3 = Controls are in place to prevent IPs but there is room for improvement

2 = Minimal controls are in place to prevent IPs

1 = Controls are not in place to prevent IPs

Generally, as described below, the Foster Care program has sufficient controls in place to prevent improper payments. Although, as a Federally funded, state-administered program, HHS does not have management control over state agencies, HHS's reporting and analyses of improper Foster Care payments to determine the nature, extent, magnitude, and root cause(s) of improper payments has led to the implementation of a number of strategies to identify and reduce such payments and has strengthened the control environment. These strategies and the associated control environment are tailored to the nature of Foster Care improper payments resulting from administrative and documentation errors rather than from fraud and abuse. HHS has implemented effective control activities to prevent improper payments in the Foster Care program—preventive controls—and identify payments after the payments are made—detective controls. The kinds of key control activities to prevent improper payments include:

- Establishing Foster Care improper payments as an important management priority within HHS, with clear lines of accountability and responsibility within the agency.
- Providing support and feedback to states to support implementation of program improvement efforts, such as instituting specialized eligibility units to prevent eligibility errors or enhancing edits in automated systems to prevent billing errors.
- Working with the judiciary (e.g., through the Court Improvement Program) to enhance understanding of required documentation and timing of judicial hearings to prevent eligibility errors related to judicial determinations.
- Enhancing financial reporting requirements and guidance to auditors to obtain more information and improve the utility of single audit procedures.

The kinds of key control activities in place to identify improper payments after the payments are made include:

- Regular cycle of eligibility reviews, authorized by regulation, conducted by joint federal-state teams on a three-year cycle, to examine eligibility and allowability of federal IV-E payments to states.
- Recovery of all (100 percent) ineligible payments identified in eligibility reviews through disallowance of subsequent federal payment to states.
- Analyses of factors contributing to program improper payments each year, including examination of relative contributions to overall program improper payments. This yields information regarding priority areas to inform risk assessment and guide corrective action planning.
- Provision of matching funds and technical assistance for the development and enhancement of statewide automated child welfare information system (SACWIS) eligibility and financial management modules designed to improve the consistency, timeliness, and documentation available to support allowability for Title IV-E claims.

The Foster Care program also has various techniques in place to use, share, and communicate information to prevent improper payments and ensure the information is timely, accurate, and reliable. The source of information, method of distribution, and type of communication can vary widely and includes:

- Communication and technical assistance to support continuous quality improvement by states, including updates on eligibility criteria and promising practices.
- Timely written report of review findings sent to each state agency following an eligibility review. This report includes detailed, case-level descriptions of all ineligible payments, underpayments, disallowances, promising practices, areas needing improvement, and next steps for the state.
- Required PIPs, which must identify all planned corrective actions and a timeline for completion, for all states found not in substantial compliance in an eligibility review. States must also provide regular updates on progress towards completion of the PIP, and complete it in a specified timeframe.
- Annual reports to program leadership summarizing findings across all state eligibility reviews conducted during the year, and identifying common elements related to strengths, areas needing improvement, and innovative practices.

The Foster Care program also conducts a variety of monitoring and assessment activities such as:

- Regular eligibility reviews conducted by joint federal-state teams, governed by a standard review instrument and detailed procedures outlined in the Eligibility Review Guide.
- Secondary reviews of all states found to be not in substantial compliance on a primary eligibility review.
- Validation of incoming review data to ensure data integrity prior to developing annual updated estimates of program error rate and improper payments following OMB-approved methodology for the federally-funded, state-administered Foster Care program.

HHS continues to improve and evaluate its internal control activities in the Foster Care program to prevent improper payments by participating in annual OIG audits of improper payments activities and incorporating audit recommendations as feasible within program regulatory constraints.

Generally, as described below, the CCDF program has adequate controls in place to prevent improper payments. HHS's reporting and analyses of improper CCDF payments to determine the nature, extent, magnitude, and root cause(s) of improper payments has led to the implementation of several strategies to help states identify and reduce such payments and strengthened the control environment. HHS has implemented effective control activities to help states prevent improper payments in the CCDF program—preventive controls—and identify

payments after the payments are made—detective controls. The kinds of key control activities in place to prevent improper payments include:

- Targeted technical assistance to all states to assist with the reduction of errors.
- States implement system enhancements to provide worker edits (i.e., forcing workers to correct information that is entered incorrectly such as in the wrong format or location) and monitoring reports.
- States design tools to reduce errors, such as calculation tables or spreadsheets.

The kinds of key control activities in place to identify improper payments after the payments are issued include:

- States conduct ongoing case reviews.
- States conduct supervisory, peer, and quality assurance team reviews to support accuracy.

The CCDF program also has various techniques in place to use, share, and communicate information to prevent improper payments and ensure the information is timely, accurate, and reliable. The source of information, method of distribution, and type of communication can vary widely and includes:

- Annual information brief on error rate data, root causes of errors, and best practices to address the issues.
- Regular cohort training to facilitate methodology implementation, and best practices to address findings.

The CCDF program also conducts a variety of monitoring, technical assistance, and assessment activities such as:

- Training to implement the error rate measurement methodology.
- Site visits to assist grantees in addressing the root causes of errors and designing their policy and procedure mitigations.

HHS continues to improve and evaluate its internal control activities in the CCDF program to prevent improper payments.

### 13.0 Recovery Auditing Reporting

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HHS developed a risk-based strategy to implement the recovery auditing provisions of *IPERA*. Specifically, HHS focuses on implementing recovery audit programs in Medicare and Medicaid, which accounted for 85 percent of HHS's outlays in FY 2015. HHS is progressing in recovering improper payments in Medicare and Medicaid and, most importantly, implementing corrective actions to prevent improper payments, as described below.

#### **Medicare FFS RACs**

Section 302 of the *Tax Relief and Health Care Act of 2006* required HHS to implement the Medicare FFS RAC program in all 50 states no later than January 1, 2010. The current RACs are under contract to continue their active recovery auditing work through December 31, 2015. HHS currently allows the Recovery Auditors to review a variety of claim types with the exception of hospital patient status reviews. HHS has been working through the procurement process for the next Recovery Auditor contracts since 2013. Due to multiple pre- and post-award protests delaying the new contracts, HHS withdrew the Request for Proposal for this procurement in June 2015. HHS has restarted the procurement process and expects to issue revised Requests For Proposal in early FY 2016.

In FY 2015, the Medicare FFS RAC program identified approximately \$390.85 million and recovered \$359.73 million in overpayments by the end of the FY. Policy changes regarding the payment and treatment of inpatient hospital claims and a delay in awarding new Medicare FFS contracts resulted in the reduction of the number of FY 2015 reviews compared to previous years. Meanwhile, amounts that were identified in previous years continued to be collected. During FY 2015, the majority of Medicare FFS RAC collections were from Diagnosis Related Group

validations and DMEPOS provided in inpatient settings. HHS continues to monitor and make continuous improvements to the Medicare FFS RAC program activities.

In addition to using the Medicare FFS RACs to identify overpayments, HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, in FY 2015, HHS released four Provider Compliance Newsletters that offered detailed information on 17 findings identified by the Medicare FFS RACs. Also, HHS used these findings to implement local and/or national system edits as internal controls to prevent improper payments. More information on the Medicare FFS RAC program can be found at: [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program).

#### ***Medicare Secondary Payer RACs***

The Medicare Secondary Payer (MSP) RAC began full recovery operations at the end of FY 2013 and operates as the MSP Commercial Repayment Center (CRC). The CRC reviews HHS information regarding beneficiaries that had or have primary coverage through an employer-sponsored Group Health Plan (GHP). When that information is incomplete, Medicare FFS may mistakenly pay for services as the primary payer. The CRC recovers these mistaken payments from the entity that had primary payment responsibility (typically the employer or other plan sponsor, insurer, or claims processing administrator). The debtors for these MSP debts do not have formal appeal rights, but do have the opportunity to dispute the debt through the established “defense” process.

In FY 2015, the CRC identified approximately \$292.20 million and collected \$149.60 million in mistaken payments. In FY 2016, the CRC workload will expand to include the recovery of certain Non-Group Health Plan (NGHP) conditional payments where an NGHP entity has or had primary payment responsibility. More information on the CRC can be found at: [www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Group-Health-Plan-Recovery/Group-Health-Plan-Recovery.html](http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Group-Health-Plan-Recovery/Group-Health-Plan-Recovery.html).

#### ***Medicare Part C and Part D RACs***

Section 6411(b) of the *Affordable Care Act* expanded the RAC program to Medicare Parts C and D. As part of the procurement process to secure a Medicare Part C RAC, HHS posted a Request for Quote in June 2014; however, no responses were received as a result of that solicitation. HHS continues its implementation efforts and anticipates awarding a Part C RAC contract in 2016.

The Part D RAC became fully operational in FY 2012, and is currently reviewing prescription drug event data for calendar years 2010 through 2013. Since its launch, the Part D RAC recouped overpayments made as a result of prescriptions written by excluded or unauthorized providers or filled at excluded pharmacies. The Part D RAC recouped approximately \$5.2 million in FY 2015. Additionally, in FY 2015, the Part D RAC identified improper payments for improper refills of Drug Enforcement Agency (DEA) scheduled drugs for calendar years 2010 through 2011. Notifications of improper payment were sent to plan sponsors in February 2015, totaling approximately \$2.8 million and recoupments are expected to occur in FY 2016.

More information on the Medicare Part C and Part D RAC programs can be found at: [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/).html.

#### ***State Medicaid RACs***

Section 6411(a) of the *Affordable Care Act* required states to submit assurances by December 31, 2010 that their programs meet the statutory requirements to establish State Medicaid RAC programs. States were required to implement RAC programs by January 1, 2012. Thus, FY 2015 is the third full federal FY of reporting State Medicaid RAC recoveries. As states continue to implement their State Medicaid RAC programs, State Medicaid RAC federal-share recoveries totaled \$57.71 million in FY 2015. State Medicaid RAC federal-share recoveries include overpayments collected, adjusted, or refunded to HHS, as reported by states on the CMS-64.

HHS regulations align the State Medicaid RAC requirements to existing Medicare FFS RAC program requirements, where feasible, and provide each state the flexibility to tailor its RAC program where appropriate. As of the end of FY 2015, 47 states and the District of Columbia had implemented Medicaid RAC programs, but one of those states ended its RAC program when HHS approved an exception due to high managed care penetration. Four states currently have HHS-approved exceptions to Medicaid RAC implementation due to small beneficiary populations or high managed care penetration.

HHS provides guidance as the States administer the Medicaid RAC program. In September 2012, HHS launched a tool to encourage transparency and monitoring called the State Medicaid RACs At-A-Glance website, which is located at: [w2.dehpg.net/RACSS/Map.aspx](http://w2.dehpg.net/RACSS/Map.aspx). The website contains state-reported information on each State's Medicaid RAC program, the name of each RAC vendor and Medical Director, and contact information for the state program integrity staff.

#### ***Recovery Auditing Reporting Tables***

OMB Circular A-136 requires agencies to provide detailed information on their recovery auditing programs, as well as other efforts related to the recapture of improper payments. Some of our programs have results to report in this area and those results are included in the following tables. If a program is not listed on a certain table, it is because they do not yet have results in that area.

**Table 4**  
**Improper Payment Recaptures with and without Audit Programs**  
FY 2015 (in Millions)

Program or Activity	Payment Recapture Audits of Contracts					Payment Recapture Audits of Benefits					Total		Overpayments Recaptured Outside of Payment Recapture Audits	
	Amount Identified	Amount Recaptured	CY Recapture Rate Note (2)	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured	CY Recapture Rate Note (1)	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured	Amount Identified	Amount Recaptured
Medicare FFS Error Rate Measurement													\$39.71	\$30.68
Medicare FFS Recovery Auditors	\$390.85	\$359.73	92.04%	85.00%	85.00%						\$390.85	\$359.73		
Medicare Secondary Payer Recovery Auditor Note (2)	\$292.20	\$149.60	51.20%	85.00%	85.00%						\$292.20	\$149.60		
Medicare Contractors Note (3)													\$14,523.62	\$11,554.30
Medicare Part C Note (4)													\$648.84	\$648.84
Medicare Part C Recovery Auditors Note (5)														
Medicare Part D Note (4)													\$11.57	\$11.57
Medicare Part D Recovery Auditors	\$2.76	\$5.16	186.96%	85.00%	85.00%						\$2.76	\$5.16		
Medicare C RADV Audits Note (6)														
Medicaid Error Rate Measurement													\$4.40	\$1.02
CHIP Error Rate Measurement													\$1.91	\$0.81
Medicaid Integrity Contractors- Federal Share Note (7)													\$22.13	\$8.23
State Medicaid Recovery Auditors – Federal Share Note (8)						N/A	\$57.71	N/A	N/A	N/A	N/A	\$57.71		
Foster Care Eligibility Reviews-Post Payment Reviews													\$0.99	\$0.99
Foster Care OIG Reviews													\$0.00	\$0.00

Program or Activity	Payment Recapture Audits of Contracts					Payment Recapture Audits of Benefits					Total		Overpayments Recaptured Outside of Payment Recapture Audits	
	Amount Identified	Amount Recaptured	CY Recapture Rate Note (2)	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured	CY Recapture Rate Note (1)	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured	Amount Identified	Amount Recaptured
Foster Care Single Audits													\$0.82	\$0.05
Child Care Single Audits													\$0.99	\$0.00
Child Care Error Rate Measurement Note (9)													\$0.14	\$0.02
Head Start OIG Reviews													\$0.11	\$0.00
Head Start Single Audits													\$2.55	\$0.19
<b>TOTAL</b>	\$685.81	\$514.49	75.02%	85.00%	85.00%		\$57.71				\$685.81	\$572.20	\$15,257.78	\$12,256.70

## Notes:

1. The amount reported in the CY Recapture Rate column is the amount recovered in FY 2015, regardless of the year the overpayment was identified.
2. The Medicare Secondary Payer recovery auditor maintains all debts established under prior MSP recovery programs; consequently, the reported collections is the amount recovered in FY 2015, regardless of the year the mistaken payment was identified.
3. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS recovery auditors program and the Medicare FFS Error Rate Measurement program, which are reported separately in this table.
4. The values in the Medicare Part C and Medicare Part D rows represent overpayments reported and returned by Medicare Advantage organizations and Part D sponsors, respectively.
5. HHS expects to award a contract for a Medicare Part C RAC program in FY 2016.
6. During FY 2015, HHS continued the contract-level RADV audits based on calendar year 2011 and launched the calendar year 2012 audits. As such, there were no RADV payment amounts identified or recovered in FY 2015.
7. For Medicaid, the Medicaid Integrity Contractors (MICs) identified total overpayments which include both the federal and state shares. However, HHS has reported here only the actual federal share across audits.
8. For state Medicaid recovery auditor programs, states are only required to report the amount of recoveries on the CMS-64, and not amount of improper payments identified or recovery rates or targets.
9. The Child Care Error Rate Measurement information reflects overpayments that are identified through the statistical sampling process. The information reported represents the amount that is subject to disallowance. For the Child Care Error Rate Measurement Amount Recaptured information, states are required to recover child care payments that are the result of fraud and have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error. Data reported in FY 2015 represent improper payments recovered by the Year Two states based on improper payments identified in FY 2012.



**Table 5**  
**Disposition of Funds Recaptured Through Payment Recapture Audits**  
 FY 2015 (in Millions)

Program or Activity	Amount Recovered	Type of Payment	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose Note (1)	Office of Inspector General	Returned to Treasury
Medicare FFS Recovery Auditors	\$359.73	Contract	\$75.62	\$20.25	N/A	\$182.89	N/A	N/A
Medicare Secondary Payer Recovery Auditor	\$149.60	Contract	\$2.49	\$22.06	N/A	\$125.05	N/A	N/A
Medicare Part D Recovery Auditors	\$5.16	Contract	N/A	\$0.62	N/A	\$4.54	N/A	N/A
State Medicaid Recovery Auditors – Federal Share Note (2)	\$57.71	Benefits	N/A	N/A	N/A	N/A	N/A	\$57.71
<b>Total</b>	<b>\$572.20</b>		<b>\$78.11</b>	<b>\$42.93</b>	<b>N/A</b>	<b>\$312.48</b>	<b>N/A</b>	<b>\$57.71</b>

## Notes:

1. Funds included under the "Original Purpose" column were returned to the Medicare Trust Funds after taking into consideration agency expenses to administer the program and recovery auditor contingency fees. In addition, the Medicare FFS Recovery Auditors "Original Purpose" cell also takes into consideration underpayments to providers that were identified and corrected (\$80.96 million).
2. The state Medicaid recovery auditors row only includes information on the federal share of recoveries, which are returned to Treasury. States do not report information to HHS on how the state portions of recoveries are used.

**Table 6**  
**Aging of Outstanding Overpayments Identified in the Payment Recapture Audits**  
 FY 2015 (in Millions)<sup>Note (1)</sup>

Program or Activity	Type of Payment	CY Amount Outstanding (0 – 6 months)	CY Amount Outstanding (6 months to 1 year)	CY Amount Outstanding (over 1 year)	Amount Determined to Not be Collectable
Medicare FFS Recovery Auditors	Contract	\$61.43 Note (2)	\$26.16	\$1,056.56	N/A
Medicare Secondary Payer Recovery Auditor Note (3) and (4)	Contract	\$92.81	\$87.68	\$0.00	\$0.00
Medicare Part D Recovery Auditors	Contract	N/A Note (5)	N/A	N/A	N/A
<b>Total</b>		<b>\$154.24</b>	<b>\$113.84</b>	<b>\$1,056.56</b>	<b>\$0.00</b>

## Notes:

1. The state Medicaid recovery auditors are not included in this table since states do not report information to HHS that would allow the Department to calculate the aging of overpayment amounts that are currently outstanding.
2. Under the Medicare FFS recovery auditors program, recovery of identified overpayments cannot begin until the overpayment is at least 41 days old. Therefore, the CY Amount Outstanding (0-6 months) includes identified overpayments that HHS cannot begin collecting.
3. The Medicare Secondary Payer recovery auditor maintains debts established under prior MSP recovery programs; consequently, collections exclusively related to mistaken payments identified by the MSP recovery auditor does not directly correlate to the amount outstanding.
4. The amount of outstanding payments identified by the Medicare Secondary Provider recovery auditor included in this table reflect the outstanding balances on debts identified in FY 2015 only as of the end of FY 2015.
5. Recoupments of FY 2015 overpayments will not begin on the Medicare Part D recovery auditors' overpayments until the appeals process is complete. The appeals process is ongoing, but is expected to be completed during FY 2016.

## 14.0 Do Not Pay Initiative

In June 2010, the President issued a Memorandum on Enhancing Payment Accuracy Through a "Do Not Pay List," which underscored that:

While identifying and recapturing improper payments is important, prevention of payments before they occur should be the first priority in protecting taxpayer resources from waste, fraud, and abuse. In those cases where data available to agencies clearly shows that a potential recipient of a Federal payment is ineligible for it, subsequent payment to that recipient is unacceptable. We must ensure that such payments are not made.

So as "to ensure that only eligible recipients receive Government benefits or payments," the President directed the establishment of a "single point of entry" through which agencies would access relevant data - in a network of databases to be collectively known as the "Do Not Pay List"- before determining eligibility for a benefit, grant or contract award, or other federal funding. Subsequently, the "Do Not Pay List" was codified by IPERIA, which included a requirement for agencies to check relevant databases prior to making an award or payment. The Presidential memorandum and IPERIA identified the following databases to include in the Do Not Pay (DNP) portal: the Social Security Administration's (SSA) Death Master File (DMF), the HHS OIG's List of Excluded Individuals & Entities (LEIE), the General Service Administration's System for Award Management (SAM) exclusion records (also referred to as the Excluded Party List System), the Treasury's Debt Check, the Department of Housing and Urban Development's Credit Alert Interactive Voice Response System (CAIVRS), and the SSA's Prisoner Update Processing System (PUPS). Treasury's "Do Not Pay" website – [www.donotpay.treas.gov/index.htm](http://www.donotpay.treas.gov/index.htm) - includes information on currently available and pending data sources in the DNP portal.

Since the Presidential memorandum was issued, and IPERIA was enacted, HHS has worked diligently to implement the DNP initiative. HHS and CMS established a Computer Matching Agreement (CMA) with Treasury under the DNP initiative in FY 2014. The CMA allows HHS to match electronic files against restricted content (such as Social Security Number, Date of Birth, or Taxpayer Identification Number (TIN)) in some of the data sources, simultaneously reducing the time to complete the matches while also producing more accurate results. HHS has continued to receive information through the CMA that was established in FY 2014 and began working to establish additional CMAs in FY 2015. In addition, several of our Divisions are continuing to use DNP to check for recipients or potential recipients' eligibility and to prevent the issuance of improper payments.

Treasury-disbursed payments are matched against the DMF and the excluded parties' elements of SAM in the DNP portal to identify improper payments on a daily basis. While the Department has identified 530 potential improper payments over the past year as part of these daily matches (as shown in Table 7), there was only one confirmed improper payment for \$6,521.00.

**Table 7**  
**Results of the Do Not Pay Initiative in Preventing Improper Payments**  
FY 2015

	Number (#) of payments reviewed for possible improper payments	Dollars (\$) of payments reviewed for possible improper payments	Number (#) of payments stopped	Dollars (\$) of payments stopped	Number (#) of potential improper payments reviewed and determined accurate	Dollars (\$) of potential improper payments reviewed and determined accurate.
Reviews with the IPERIA specified databases Note (1)	1,182,453 Note (2)	\$362,611,594,950	0 Note (3)	0 Note (3)	530 Note (4)	\$97,753,865 Note (4)
Reviews with databases not listed in IPERIA	N/A	N/A	N/A	N/A	N/A	N/A

## Notes:

1. This row shows payments that are disbursed through Treasury and matched against IPERIA specified databases. However, Medicare FFS payments are not disbursed by Treasury but are also matched against databases listed in IPERIA. HHS is currently developing the systems requirements to automate the capture of this information for Medicare FFS payments, and will report this data in the FY 2016 AFR.
2. HHS data included 1,962 payment records which contained missing or invalid information.
3. "Payments Stopped" refers to payments for which the agency has implemented Stop Payment Rules or a similar method of disbursement prevention during the pre-payment stage. It does not include post-payment reclamations, collections, or offsets.
4. This includes information on payments that were flagged as potentially improper, but were determined proper after further review.

## 15.0 Superstorm Sandy Reporting Information

Superstorm Sandy was a major hurricane that struck the United States' (U.S.) eastern seaboard on October 29, 2012 and caused extensive damage from Florida to Maine, with New Jersey and New York sustaining the most damage. Sandy was the second costliest hurricane in U.S. history, causing \$68 billion worth of damage, draining state funds, and stretching limited resources.

In response to this disaster, Congress passed the *Disaster Relief Act*, which was signed into law on January 29, 2013 and provided \$50.5 billion in aid for Sandy disaster victims and their communities. HHS received \$747 million, allocated among multiple programs across five Divisions: ACF, ASPR, CDC, SAMHSA, and NIH. Because funding of this type and magnitude often carries additional risk, the *Disaster Relief Act* and OMB guidance state that all federal programs or activities receiving funds are automatically considered susceptible to significant improper payments, regardless of any previous improper payment risk assessment results, and are required to calculate and report an improper payment estimate. Accordingly, HHS developed methodologies to estimate improper payments in the programs that received *Disaster Relief Act* funding. Information on the *Disaster Relief Act* programs' improper payment methodologies, results, and corrective actions can be found on subsequent pages.

### 15.10 Head Start

#### 15.11 Head Start Statistical Sampling Process and Results

Head Start received approximately \$95 million in *Disaster Relief Act* funding to provide services, training and oversight, and construction assistance to affected grantees. Every grantee who spends Superstorm Sandy funds receives an erroneous payments onsite monitoring visit in the quarter following the quarter when funds are spent, or as soon thereafter as possible. Superstorm Sandy transactions for each quarter are reviewed using a standard onsite monitoring tool to identify potential and actual erroneous payments. Additional information on Head Start's statistical sampling process can be found on pages 198 - 199 of HHS's FY 2014 AFR, available at: [www.hhs.gov/afr](http://www.hhs.gov/afr).

The FY 2015 review period consisted of transactions representing funds expended by grantees between July 1, 2014 and June 30, 2015. HHS expects FY 2015 to have the largest number of Head Start Superstorm Sandy transactions because during this period, awardees were completing minor repairs and renovations, re-supplying centers and classrooms, providing mental health services, implementing major facilities renovations, and rebuilding seriously damaged or destroyed centers.

The Head Start gross and net improper payment estimate for FY 2015 is 0.38 percent or \$61,626.36.

## 15.12 Head Start Root Causes and CAPs

### Corrective Actions to Address Root Cause

#### ***Root Cause: Administrative or Process Error Made by Local Agencies***

All of the identified Head Start erroneous payments were administrative or process errors made by the grantees (100 percent). Most of the identified erroneous payments were caused by human error, such as transposed numbers. The largest single error amount identified was for \$22,772 and was due to an error in the allocation of the salary and fringe benefits for a supervisory employee. For this error, the grantee neglected to adjust its cost allocation methodology to reflect the change in duties for the employee once her Sandy-related duties ended. Additionally, some of the erroneous payments were self-identified by the grantee as part of their internal monitoring processes. Technical assistance to grantees has consequently emphasized the need for ongoing internal monitoring of transactions by grantees and comparison of amounts paid to source documentation.

## 15.13 Head Start Improper Payment Recovery

All improper payments made to Head Start awardees have been recovered through direct repayment or offset against subsequent Superstorm Sandy awards.

## 15.20 SSBG

### 15.21 SSBG Statistical Sampling Process and Results

The SSBG program received \$474.5 million in *Disaster Relief Act* funding to address necessary expenses resulting from Superstorm Sandy. These expenses include social, health, and mental health services for individuals, and repair, renovation and rebuilding of health care facilities (including mental health facilities), childcare facilities, and other social services facilities. These SSBG *Disaster Relief Act* funds were allocated to five states directly affected by Superstorm Sandy: Connecticut, Maryland, New Jersey, New York, and Rhode Island. HHS selected three of the five states that received SSBG *Disaster Relief Act* funds (Connecticut, New Jersey, and New York) to calculate improper payment error rates, since their allocations represent 99 percent of all SSBG *Disaster Relief Act* funds.

Because the states determine the types of services and eligibility for these services, as permitted by the SSBG law and regulations, there is considerable variation among states in their application of these funds. To account for this variation, HHS developed a two-fold (bifurcated) improper payment methodology to review the use of SSBG *Disaster Relief Act* funds in Connecticut, New Jersey, and New York. The two approaches are a case record review process and a vendor payment review process. The case record review examines payments or benefits provided to or on behalf of individuals, families or households (i.e., cases) based on specific eligibility criteria. The vendor payment review examines individual payments made to service vendors and assesses if the vendors provided adequate documentation (e.g., applications, authorizations) necessary to meet the eligibility requirements for these payments.

For the FY 2015 review period (July 1, 2014 to June 30, 2015), HHS completed case record and vendor payment reviews in Connecticut, New Jersey, and New York. HHS consolidated its review findings and calculated a national SSBG Superstorm Sandy *Disaster Relief Act* error rate from the aggregate findings across all three states.

In FY 2015, HHS used an error rate estimate of 10 percent to determine sample sizes for the case record and vendor payment reviews with a 90 percent confidence interval of +/-2.5 percent. HHS continued to estimate a base error rate of 10 percent when establishing sample sizes for FY 2015, despite calculating a national SSBG error rate for FY 2014 at 13.48 percent.

FY 2014 improper payment reviews consisted only of a case record review in New Jersey. This was due both to a lack of applicable expenditures in Connecticut and New York, and to the vendor payment review remaining under development at the time of the FY 2014 improper payment reviews. A majority of funds in error in FY 2014 (74 percent) were attributed to a single vendor within New Jersey's Sandy Homeowner and Renter Assistance Program (SHRAP), which accounted for approximately 92 percent of all expenditures reviewed in FY 2014. Many of the recorded errors were due to missing documentation at the time of the review. The state ultimately retrieved much of the documentation missing at the time of the review, which would have reduced the calculated error rate to approximately five percent. However, the state was unable to provide this documentation in time to reassess the established SSBG error rate for FY 2014.

While the FY 2014 SSBG *Disaster Relief Act* error rate was greater than the initially estimated 10 percent, HHS felt it was inappropriate to adjust its SSBG *Disaster Relief Act* error rate estimate for all reviews in all states based on the results of a case record review occurring in one state. As such, HHS retained a base error estimate of 10 percent when generating samples for the FY 2015 improper payment reviews.

HHS reviewed a total of 1,152 records in FY 2015. For the case record review, HHS reviewed 580 case records across the three states – 53 cases in Connecticut, 383 cases in New Jersey, and 144 cases in New York. For the vendor payment review, HHS reviewed 572 vendor payments across the three states – seven payments in Connecticut, 224 payments in New Jersey, and 341 payments in New York.

The SSBG gross improper payment estimate for FY 2015 is 0.22 percent or \$0.46 million. The FY 2015 net improper payment estimate is 0.22 percent or \$0.45 million.

The error rate for the case record reviews was 1.18 percent, while the error rate for the vendor payments was 0.18 percent.

## 15.22 SSBG Root Causes and CAPs

Of the 1,152 records reviewed, 45 records had an improper payment.

Five errors (representing 53.4 percent of the estimated improper payments) were categorized as Administrative or Process Errors due to State or local agencies. These errors included: (1) missing signatures on payment processing forms required as part of payment approval; or (2) clerical errors in calculating payment amounts based on vendor claims.

Eight errors (representing 14.8 percent of the estimated improper payments) were categorized as Administrative or Process Errors due to other parties (i.e., non-Federal, non-State, and non-local agencies). These errors included: (1) clients receiving incorrect benefit amounts (greater or lesser) based on documented need; (2) clients receiving benefits before providing all necessary eligibility documentation; (3) clients receiving benefits despite documentation indicating ineligibility for service; or (4) benefit payments being made on behalf of someone outside of the client's household.

Thirty-two errors (representing 31.8 percent of the estimated improper payments) were categorized as Insufficient Documentation to Determine. These errors included: (1) case records missing necessary eligibility documentation (e.g., driver's license, passport); or (2) records missing necessary documentation of proper payment processing (e.g., proof of payment, payment approval forms, copies of bills/invoices to be paid).

### **Corrective Actions to Address Root Causes:**

HHS implemented a series of monitoring and oversight activities in all states to address problems of burden, information exchange, and organization of review materials highlighted in the FY 2014 improper payment findings. HHS has worked with the state to address issues related to document processing and will continue to coordinate with the state on additional corrective actions including payment recapture where necessary. HHS activities have included drawing quarterly improper payment samples for review and formalizing a 30-day response period for states upon completion of each review. The 30-day response period allowed states to clarify payment policies or provide missing documentation that may have been mistakenly left out during the organization and assembly of files for review.

In response to FY 2015 improper payment findings, HHS will provide each state subject to review with a letter outlining the development of CAPs. These letters will be accompanied by itemized lists of unresolved errors from the FY 2015 review period (including descriptions of improper payment findings and amounts), and will establish a 30-day timeframe for states to respond with planned corrective actions. HHS will also hold calls with each state to answer any questions related to developing CAPs or establishing improper payment recovery amounts. In developing their responses, states may provide an explanation for recovery amounts to be sought for each error; however, HHS retains final discretion in determining total amounts of funds subject to recovery. Further information on specific root causes and corrective actions is located below.

#### ***Root Cause: Administrative or Process Errors Made by State or Local Agency***

To address administrative or process errors due to State or local agencies, HHS will develop strategies with states to monitor and provide oversight to the most error-prone agencies. These strategies will reinforce the importance of ensuring that all documentation required for payment processing is present and complete before payments are approved. These activities will also emphasize careful examination of receipts and invoices to ensure that payments made by the states properly reflect established payment schedules and reimbursement protocols. HHS will continue to work with states to examine where in their payment approval processes the greatest intervention is warranted.

#### ***Root Cause: Administrative or Process Errors Made by Other Party***

To address administrative or process errors due to other parties, HHS will develop strategies with states to monitor and provide oversight to the most error-prone service providers. These strategies will reinforce the importance of: (1) collecting all client eligibility documentation prior to provision of service benefits; (2) ensuring that eligibility documentation is properly examined, and that ineligible individuals do not receive service benefits; and (3) ensuring that benefits provided to clients match their documented needs. HHS will continue to work with states to address how error-prone vendors can improve their client intake processes and improve processes for assessing and approving client benefits.

**Root Cause: Insufficient Documentation to Determine**

To address errors due to insufficient documentation, HHS will develop strategies with states to monitor and provide oversight to the most error-prone service agencies and providers. These strategies will reinforce the importance of record maintenance and organization. HHS will work with states to assess typical practices of record maintenance and organization.

**15.23 SSBG Improper Payment Recovery**

Of the total error findings, \$457,434 was associated with overpayments. As states receive and review all unresolved errors from the FY 2015 review period, HHS will work with states to identify items for which additional corrective action will be taken (including obtaining additional documentation, making process adjustments, and the current state of improper payment recovery). Where additional action around improper payment recovery is warranted, HHS will work with states to focus recovery efforts on improper payments resulting from core eligibility errors, where benefits or payments should not have been paid.

**15.30 FVPS****15.31 FVPS Statistical Sampling Process and Results**

The Family and Youth Services Bureau's Division of Family Violence Prevention and Services (FVPS) received \$2 million in *Disaster Relief Act* funding to prevent domestic violence in affected states. This funding is used for multiple purposes and HHS identified financial alternative housing assistance as most susceptible to improper payments; therefore, these are the payments that are measured. Alternative housing assistance benefits are paid directly to third parties on behalf of an individual recipient by the New Jersey Department of Children and Families (NJDCF) and the New York State Office of Children and Family Services (NYSOCFS).

HHS determined that each state grantee would sample 45 percent of its financial alternative housing payments during each review period to generate a statistically valid estimate. If the number of payments in any review period is less than 110, then 100 percent of the payments will be reviewed. In FY 2015 (review period July 1, 2014 to June 30, 2015), FVPS reviewed 371 payments, with 220 payments coming from the NJDCF and 151 payments from the NYSOCFS.

FVPS' gross and net improper payment estimate for FY 2015 is 0.89 percent or \$7,944.85.

**15.32 FVPS Root Causes and CAPs**

Of the 371 payments that were reviewed, HHS determined four payments were in error due to Administrative or Process Error Made by the State or Local Agency (100 percent). One of the improper payment errors was an overpayment by a NJDCF sub awardee due to an error made by the local awardee. The other three improper payment errors were overpayments made by NYSOCFS subawardees that resulted from the subawardees' failure to correctly classify ineligible or unallowable expenses. For example, multiple programs had unallowable expenses (purchases of household goods) due to misinterpretation of allowable expenses for "basic, essential items."

**Corrective Actions to Address Root Cause:****Root Cause: Administrative or Process Error Made by State or Local Agency**

To reduce the likelihood of future improper payments, HHS has: (1) shared the improper payment findings with NJDCF and NYSOCFS, and (2) provided technical assistance and clarification on allowable versus unallowable expenses with future supplemental funding. In addition, both states identified internal corrective actions to prevent errors. For example, NJDCF required that domestic violence provider agencies send a list of the "basic,

essential items” that a co-trauma victim was requesting prior to disbursement of funds. NJDCF then sent the request to HHS for approval to determine which items were allowable. In addition, NJDCF distributed a frequently asked question (FAQ) document on October 28, 2014 to all provider agencies in order to assist in reducing unallowable expenditures. This FAQ was developed by HHS as a technical assistance aid for both state grantees to reduce improper payments. NYSOCFS provided written notification of the improper payment findings to its sub-grantees with instructions to refund the specified amounts to NYOCFS.

The grant period for both awards ended on June 30, 2015. No further expenditures or reimbursements were made after that period; therefore, there will be no further monitoring or reporting on improper payments.

### 15.33 FVPS Improper Payment Recovery

It is estimated that all of the actual identified overpayments will be recovered by the grantees and will be returned to the Department of Treasury.

### 15.40 ASPR Research

#### 15.41 ASPR Research Statistical Sampling Process and Results

ASPR received approximately \$11.9 million in *Disaster Relief Act* funding to evaluate preparedness and response activities in the affected states. ASPR’s Superstorm Sandy improper payment methodology will be conducted in two stages. The first stage, for FY 2014 reporting, reviewed the eligibility of grantees that received funding in FY 2013. The second stage of the methodology was implemented for FY 2015 and will continue into FY 2016. The methodology calculates an unallowable spending error rate (e.g., unallowable expenses, lack of documentation) based on a review of each grantee’s expenditures during the review period. The sample for the FY 2015 reporting period consisted of expenditures during FY 2014 (October 1, 2013 to September 30, 2014), and the sample for the FY 2016 reporting period will consist of expenditures made during FY 2015 (October 1, 2014 to September 30, 2015).

Based on a review of over 1,000 transactions from FY 2014, the ASPR Research gross and net improper payment estimate for FY 2015 is 0 percent or \$0 million.

#### 15.42 ASPR Research Root Causes and CAPs

##### Corrective Actions to Address Root Cause:

##### *Root Cause:*

Although HHS has not identified any improper payments in the ASPR Research program in FY 2015, HHS established internal controls to prevent future improper payments from occurring. In FY 2015, no improper payments were found. However, ASPR will continue to monitor the *Disaster Relief Act* funding and related key processes. Major accomplishments in FY 2015 include:

- Revising the *Disaster Relief Act* sub-cycle memorandum to reflect updates within the process.
- Revised the improper payment methodology.

#### 15.43 ASPR Research Improper Payment Recovery

No recoveries will be attempted as no improper payments were identified.



## 15.50 CDC Research

### 15.51 CDC Research Statistical Sampling Process and Results

To date, CDC received approximately \$8.2 million under the *Disaster Relief Act* to perform environmental health studies and provide public health support, of which approximately \$7.2 million represents *Disaster Relief Act* funds awarded to grantees. The CDC's Notice of Award required awardees to include additional documentation to support the line items on the Federal Financial Report (FFR). This additional documentation includes grantees internally generated reports or extracts of expenses. Under its methodology, CDC reviewed these documents to identify improper payments due to causes including: unallowable costs, unallocable costs, and goods and/or services not received. The FY 2015 sampling methodology included quarterly reviews of draw down activity and transactions from July 1, 2014 through June 30, 2015 for each grantee that spent *Disaster Relief Act* funding during the review period, covering 1,050 transactions representing approximately \$4.6 million in outlays.

The CDC Research gross and net improper payment estimate for FY 2015 is 0 percent or \$0 million.

### 15.52 CDC Research Root Causes and CAPs

#### Corrective Actions to Address Root Cause:

##### **Root Cause:**

No improper or erroneous payments were identified during the FY 2015 review; therefore there is no root cause information. In FY 2014, CDC established internal controls to prevent future improper payments from occurring. Specifically, CDC developed a Risk Mitigation Plan for the CDC Research program that outlines steps to prevent improper payments in the Superstorm Sandy funding. The CDC continued to use their Risk Mitigation Plan during FY 2015 due to its success in preventing Superstorm Sandy improper payments.

### 15.53 CDC Research Improper Payment Recovery

No recoveries will be attempted as no improper payments were identified.

## 15.60 SAMHSA

### 15.61 SAMHSA Statistical Sampling Process and Results

SAMHSA received \$10 million under the *Disaster Relief Act*. SAMHSA awarded approximately \$6.2 million to four programs and returned approximately \$3.8 million because fewer organizations applied for the funding and applications received were for amounts significantly less than expected. The four funded programs were: 1) Behavioral Health Treatment; 2) Disaster Distress Helpline; 3) Resiliency Training for Educators; and 4) Medication Assisted Treatment of Opioid Addiction Restoration.

For FY 2015, SAMHSA's program universe subject to sampling consisted of four grants awarded to New York State (\$798,339), New York City (\$2,947,786), New Jersey (\$329,120), and Links2Health (\$2,100,000) for the four funded programs listed above. Between July 1, 2014 and June 30, 2015, SAMHSA had outlays of \$1.3 million across 24 transactions. Due to the small number of transactions, SAMHSA reviewed all outlays for payment accuracy and used the results to calculate the total improper payments for the program.

SAMHSA's actual gross improper payments for FY 2015 is 1.38 percent or \$18,166; the net improper payments estimate is 0.15 percent or \$2,006.

## 15.62 SAMHSA Root Causes and CAPs

SAMHSA's improper payments identified during the review period were due to Administrative or Process Errors Made by the Grantees (100 percent). The total gross improper payments of \$18,166 were due to errors in the calculation of direct and indirect expenses.

### Corrective Actions to Address Root Cause:

#### **Root Cause: Administrative or Process Errors Made by Other Party**

SAMHSA's improper payment results were discussed with each grantee and the grantees concurred with the findings. Efforts to reduce future improper payments include: (1) improving grantee processes for ensuring adequate supporting documentation is maintained; (2) ongoing examinations by SAMHSA grants management specialists of documentation supporting grantee drawdowns; and (3) developing and disseminating additional guidance to grantees to govern the conditions under which drawdowns can be made and the supporting evidence that should be maintained.

## 15.63 SAMHSA Improper Payment Recovery

SAMHSA has corrected the entire \$18,166 in improper payments. The \$10,086 in overpayments was refunded to SAMHSA and the \$8,080 in underpayments was subsequently drawn down by the grantee.

## 15.70 NIH Research

### 15.71 NIH Research Statistical Sampling Process and Results

NIH received \$148.7 million in funds under the *Disaster Relief Act* to support recovery efforts at eligible impacted universities and research institutions. These funds will restore NIH's investment in biomedical research and infrastructure that was severely damaged or destroyed by Superstorm Sandy.

Due to the variable grant expenditure amounts, NIH implemented a stratified random sampling process, with the sampling frame being divided into mutually exclusive groups or "strata" based on expenditure amount. Each sampling period consists of six months. NIH selects a random sample of expenditures from the grantees quarterly reports for the respective two quarters. The sampling unit is the total quarterly expenditures for a single award, while the sampling frame is the collection of all reports filed containing expenditures during the sampling period. NIH uses a random number generator to assign random numbers to each quarterly expenditure report. The list of expenditure reports is sorted by stratum and random number, and the appropriate number of items from each stratum is reviewed. NIH's methodology examines two areas for improper payments: (1) ensuring funds are used for an allowable program use and (2) grantee eligibility. For each grant in the sample, NIH requests detailed expenditure data and appropriate background documentation from the grantee to determine allowability. NIH also confirms grantees' continued eligibility to receive *Disaster Relief Act* funding in accordance with HHS requirements.

Under its methodology, NIH completed two rounds of improper payment reviews in FY 2014 covering 12-months of expenditures in two semi-annual sampling periods: July 1, 2013 to December 31, 2013 and January 1, 2014 to June 30, 2014. For FY 2015, NIH reviewed 357 expenditure reports representing 242 grant awards and 18 different grantee institutions, and identified improper payments of \$539,300. The improper payments were associated with one grantee institution.

The NIH Research gross and net improper payment estimate for FY 2015 is 2.29 percent or \$884,550.

## 15.72 NIH Research Root Causes and CAPs

The root cause for all improper payments identified for the review period was due to Insufficient Documentation to Determine if the grantee's reported costs were allowable pursuant to NIH's grant terms and conditions of award (100 percent).

### Corrective Actions to Address Root Cause:

#### ***Root Cause: Insufficient Documentation to Determine***

NIH will implement the following corrective actions:

- Request that the grantee conduct a review of their accounting system and related policies to identify and correct any potential weaknesses in the grantee's accounting system or methods of charging accounts specifically related to cost transfers, allocation of costs, and adherence to special terms and conditions of grant award.
- Provide the grantee with technical assistance, as required, based on the outcome of the review.
- Determine whether there are recoveries of unallowable costs after further review of the findings.
- Include the grantee in all future Sandy improper payment testing.

## 15.73 NIH Research Improper Payment Recovery

After NIH conducts a further review of the grantee's subsequent corrective actions, NIH will be in a position to determine whether there are recoveries of unallowable costs.

## SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

As described in the “Management’s Discussion and Analysis” section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to the material weakness identified during the audit, as well as conformance with FMFIA and compliance with FFMIA.

**Table 1: Summary of Financial Statement Audit**

Audit Opinion			Unmodified for Four Financial Statements. No Opinion Expressed on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			No		
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
Financial Reporting, Systems, Analyses & Oversight	–	–	–	–	–
Financial Management Close and Review Processes	–	–	–	–	–
Financial Information Management Systems	<b>1</b>	–	–	–	<b>1</b>
<i>Total Material Weaknesses</i>	<b>1</b>	–	–	–	<b>1</b>

**\*Definition of Terms – Tables 1 and 2**

**Beginning Balance:** The beginning balance will agree with the ending balance of material weaknesses from the prior year.

**New:** The total number of material weaknesses that have been identified during the current year.

**Resolved:** The total number of material weaknesses that have dropped below the level of materiality in the current year.

**Consolidated:** The combining of two or more findings.

**Reassessed:** The removal of any finding not attributable to corrective actions (e.g., management has re-evaluated and determined a material weakness does not meet the criteria for materiality or is redefined as more correctly classified under another heading (e.g., section 2 to a section 4 and vice versa).

**Ending Balance:** The agency’s year-end balance.

**\*Reference:** OMB Circular A-136, *Financial Reporting Requirements*, August 4, 2015, page 150

**Table 2: Summary of Management Assurances**

<b>Effectiveness of Internal Control over Financial Reporting (FMFIA #2)</b>						
Statement of Assurance	Qualified					
<b>Material Weaknesses</b>	<b>Beginning Balance</b>	<b>New</b>	<b>Resolved</b>	<b>Consolidated</b>	<b>Reassessed</b>	<b>Ending Balance</b>
Information System Controls and Security	1	-	-	-	-	1
<b>Total Material Weaknesses</b>	<b>1</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1</b>

<b>Effectiveness of Internal Control over Operations (FMFIA #2)</b>						
Statement of Assurance	Qualified					
<b>Material Weaknesses</b>	<b>Beginning Balance</b>	<b>New</b>	<b>Resolved</b>	<b>Consolidated</b>	<b>Reassessed</b>	<b>Ending Balance</b>
Information System Controls and Security	1	-	-	-	-	1
Error Rate Measurement	1	-	-	-	-	1
<b>Total Material Weaknesses</b>	<b>2</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>2</b>

<b>Conformance with Federal Financial Management System Requirements (FMFIA #4)</b>						
Statement of Assurance	Do not conform to financial management system requirements					
<b>Non-Conformances</b>	<b>Beginning Balance</b>	<b>New</b>	<b>Resolved</b>	<b>Consolidated</b>	<b>Reassessed</b>	<b>Ending Balance</b>
Information System Controls and Security	1	-	-	-	-	1
<b>Total Non-Conformances</b>	<b>1</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1</b>

<b>Compliance with Section 803(a) of the Federal Financial Management Improvement Act (FFMIA)</b>		
	<b>Agency</b>	<b>Auditor</b>
<b>1. System Requirements</b>	Lack of substantial compliance noted	Lack of substantial compliance noted
<b>2. Accounting Standards</b>	No lack of substantial compliance noted	No lack of substantial compliance noted
<b>3. USSGL at Transaction Level</b>	Lack of substantial compliance noted	Lack of substantial compliance noted

## FY 2015 TOP MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY THE OFFICE OF INSPECTOR GENERAL



DEPARTMENT OF HEALTH AND HUMAN SERVICES

### OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



**TO:** The Secretary

**FROM:** Inspector General

**DATE:** November 9, 2015

**SUBJECT:** Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2015

This memorandum transmits the Office of Inspector General's (OIG) list of top management and performance challenges facing the Department of Health and Human Services (Department). The *Reports Consolidation Act of 2000*, Public Law 106-531, requires OIG to identify these management challenges, assess the Department's progress in addressing each challenge, and submit this statement to the Department annually.

The OIG's top management and performance challenges for fiscal year 2015 are:

1. Protecting an Expanding Medicaid Program from Fraud, Waste, and Abuse
2. Fighting Fraud, Waste, and Abuse in Medicare Parts A and B
3. The Meaningful and Secure Exchange and Use of Electronic Information and Health Information Technology
4. Administration of Grants, Contracts, and Financial and Administrative Management Systems
5. Ensuring Appropriate Use of Prescription Drugs
6. Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care
7. Implementing, Operating, and Overseeing the Health Insurance Marketplaces
8. Reforming Delivery and Payment in Health Care Programs
9. Effectively Operating Public Health and Human Services Programs
10. Ensuring the Safety of Food, Drugs, and Medical Devices

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the beneficiaries of these programs. If you have any questions or comments, please contact me, or your staff may contact Christopher Seagle, Director of External Affairs, at (202) 260-7006 or [Christopher.Seagle@oig.hhs.gov](mailto:Christopher.Seagle@oig.hhs.gov).

/Daniel R. Levinson/

Daniel R. Levinson

## Management Challenge 1: Protecting an Expanding Medicaid Program from Fraud, Waste, and Abuse

### Why This Is a Challenge

Protecting the integrity of Medicaid takes on heightened urgency as expenditures and beneficiaries served continue to grow. As of September 2015, 29 states and the District of Columbia are expanding Medicaid eligibility to include a larger group of qualifying adults pursuant to the *Patient Protection and Affordable Care Act* (*Affordable Care Act*) and Medicaid waivers. Further, states that have not expanded eligibility have also seen increases in Medicaid enrollment. Taking into account the obstacles associated with expanding eligibility, along with long-standing program integrity issues, Medicaid continues to be a top management challenge for the Department of Health and Human Services (Department or HHS).

**Expansion of Medicaid Eligibility.** As of August 2015, the Centers for Medicare & Medicaid Services (CMS) reported that enrollment in Medicaid and the Children's Health Insurance Program (CHIP) had increased by 13.6 million people since *Affordable Care Act*-expanded eligibility criteria went into effect in October 2013. To ensure effective management of the expanding program, updating eligibility systems to ensure appropriate eligibility determinations and applicable Federal Medical Assistance Percentage (FMAP) is imperative. A main source of Medicaid's 6.7 percent improper payment rate (as reported in fiscal year (FY) 2014) is attributed to payments made on behalf of ineligible individuals. (For more information on improper payments, see [Management Challenge 4](#).) For example, eligibility errors occur when beneficiaries lose eligibility status because they are no longer residents of the state and/or failed to report a change in circumstances but remain enrolled in a state's Medicaid program. The Public Assistance Reporting Information System (PARIS) Medicaid Interstate Match program was designed to reduce these errors by identifying beneficiaries who are enrolled in multiple state Medicaid programs, but state participation in the match is limited and its effectiveness in reducing improper payments is inconsistent.

**Improving Oversight of Medicaid Managed Care.** As of 2011, approximately 75 percent of Medicaid beneficiaries nationwide are enrolled in managed care. To be effective, oversight must include robust program integrity measures, have and use accurate and timely data, and ensure that beneficiaries have sufficient access to services. In a December 2011 report, the Office of Inspector General (OIG) found that the predominant program integrity concerns of both states and plans are provider fraud – billing for services that were not provided, were medically unnecessary, or upcoded – and beneficiary fraud – including prescription drug abuse. Fraud or abuse by managed care plans themselves, such as manipulating bids to increase reimbursement, also pose program integrity challenges. States are required to collect and submit encounter data that document the managed care services that beneficiaries receive, but some states do not submit any data and others do not submit all of the required data elements. As a result, CMS does not have the data necessary to identify and address possible fraud, waste, and abuse. Further, OIG has identified issues that may impede beneficiaries' access to care, including limited appointment availability and varying state standards for access (e.g., states range from requiring one primary care provider for every 100 to 2,500 enrollees.).

**Improving the Effectiveness of Medicaid Data and Systems.** A functional, national Medicaid database is essential to effective oversight. However, national Medicaid data are not complete, accurate, or timely, and additional data are needed to enhance national program integrity activities. CMS still faces challenges in its attempts to improve the availability and quality of Medicaid data. Limited implementation by states has hindered CMS's Transformed Medicaid Statistical Information System (T-MSIS) initiative, which is CMS's key effort to modernize and enhance the usefulness of state Medicaid data. Other CMS attempts to improve data sharing between states have not been fully successful. For example, CMS established a data-sharing system to implement the *Affordable Care Act*

requirement that providers terminated for cause (i.e., for reasons of fraud, integrity, or quality) in one state Medicaid program, CHIP, or that have had their Medicare billing privileges revoked are terminated by all other state Medicaid programs. However, data within that system was often incomplete and did not provide useful information to states in order to carry out the *Affordable Care Act* requirement for terminating providers. OIG work found 12 percent of providers terminated for cause in one state Medicaid program in 2011 were still participating in other states' Medicaid programs as of January 2014. (For more information on data systems and information, see [Management Challenge 3](#).)

**State Policies That Inflate Federal Costs.** Long-standing concerns exist about states' Medicaid policies that result in the federal government paying a greater share of Medicaid costs than the FMAP percentages dictate. Misalignment of costs and payments at certain state-operated facilities can inflate federal costs. For example, New York Medicaid payments to state-run developmental centers were inflated by more than \$1 billion in FY 2009. In another example, Pennsylvania used a state tax on Medicaid managed care plans to draw down almost \$1 billion in federal funds over a three-year period. Additionally, the lack of transparency related to state waiver programs present challenges to ensure that payments are consistent with efficiency, economy, and quality of care, and do not improperly inflate federal costs. The Government Accountability Office (GAO) has found that CMS's approval process for section 1115 waivers may increase federal costs, in part, because it is not clear how CMS determines whether a waiver is budget neutral.<sup>26</sup>

**Ensuring Quality Care for Medicaid Beneficiaries.** OIG work has demonstrated that children enrolled in Medicaid do not receive all required preventive screenings and has identified quality-of-care concerns regarding children's treatment with antipsychotic drugs. Some of the quality-of-care concerns included poor monitoring of the children's treatment with drugs, children being prescribed the wrong treatment, and children taking too many drugs. Furthermore, OIG has identified significant and persistent vulnerabilities related to Medicaid personal care services, which often includes ineffective program safeguards intended to ensure medical necessity, patient safety, and quality. (For more information on ensuring quality in nursing home, hospice, and home-and community-based care, see [Management Challenge 6](#)).

### Progress in Addressing the Challenge

CMS is working to promote Medicaid expansion program integrity by providing technical assistance to the states, developing new procedures on eligibility determination and payment accuracy, and training state staff on reporting and accounting for expenditures of newly eligible individuals. For FYs 2014 – 2017, CMS required each state to implement an annual 50-State Medicaid and CHIP Eligibility Review Pilot program strategy.

If implemented, CMS's June 2015 Notice of Proposed Rulemaking (NPRM), which revises its Medicaid managed care regulations, may address several identified issues, including requirements for providers participating in Medicaid managed care to enroll in Medicaid, new standards for beneficiary access, more timely, complete and accurate submission of managed care encounter data to states, and increased safeguards against fraud, waste, and abuse. CMS also reports that it has updated its guidance on program integrity in Medicaid managed care.

CMS reports that it continues to improve its data and technology capabilities. In May 2015, CMS implemented T-MSIS with the first state. CMS reports that states are fully engaged in the transition from the Medicaid Statistical Information System (MSIS) to T-MSIS, which includes a CMS-led process to test implementation to address data gaps and other issues. However, CMS has not indicated when all states will be submitting T-MSIS data. CMS has also issued a NPRM to permit partial disallowance or deferral of Medicaid Management Information System

<sup>26</sup> GAO, *Medicaid Demonstrations: More Transparency and Accountability for Approved Spending are Needed*, June 24, 2015



(MMIS) expenditures if a state fails to produce all federally required program management data and information, including T-MSIS.

In response to the *Affordable Care Act* requirement regarding provider terminations, CMS reported that it implemented a new Medicaid provider termination notification system (TIBCO) in 2014. Under this new system, CMS reports that it is verifying state-submitted provider termination data before the data is made available to other states through TIBCO.

CMS is continuing to work with states to curb policies that inflate federal costs. CMS has approved a State Plan Amendment and entered into a \$1.9 billion settlement with New York for the state to repay amounts associated with inflated costs for state-run developmental centers and other related costs. Finally, CMS issued a letter to state health officials on the treatment of health care-related taxes and their effect on federal matching funding.

In response to OIG's work, CMS reported that it plans to work with states to monitor the use of antipsychotic drugs, implement additional quality measures related to treatment of children with antipsychotic drugs, and encourage states to request their managed care programs to address quality-of-care concerns by conducting periodic reviews of medical records of children treated with antipsychotic drugs. CMS also reported that it has disseminated two strategy guides on required preventive screenings to states and providers, began developing a quality measure specific to vision screenings, held listening sessions with states, and provided training related to federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). CMS reported that it performed state-specific program integrity reviews, one of which focused on curbing fraud and abuse in personal care services.

### What Needs To Be Done

CMS should continue to develop robust oversight for the Medicaid expansion. CMS must be vigilant in addressing program integrity risks associated with Medicaid expansion, including monitoring states' compliance with eligibility requirements and FMAP expenditures.

CMS should continue to work with states to ensure the submission of complete, accurate, and timely T-MSIS data. If states fail to submit timely T-MSIS data, CMS should use its statutory enforcement mechanisms or seek legislative authority to employ alternative tools to compel state participation. OIG is conducting work regarding CMS's and states' progress in implementing T-MSIS.

CMS should continue to improve the data available for states to terminate providers terminated from another state Medicaid agency, CHIP, or Medicare by implementing a mandatory state reporting requirement of all for cause provider terminations. Required reporting is a crucial part of creating a comprehensive data source and effective oversight.

CMS should strengthen its oversight of state Medicaid waivers, including monitoring the costs of such waivers, and ensure that any oversight actions taken are publicly reported.

CMS should continue to promote awareness of safe treatment and best practices for treating children with antipsychotic drugs and consider ways that states could implement periodic reviews of medical records of children who receive antipsychotic drugs. CMS should also continue its efforts to improve delivery of preventive screenings for children, particularly on required reporting of vision and hearing screenings.

### Key OIG Resources

- OIG Testimony, [Examining the Federal Government's Failure to Curb Wasteful State Medicaid Financing Schemes](#), July 2014

- [OIG Report, CMS's Process for Sharing Information About Terminated Providers Needs Improvement](#), March 2014
- [OIG Reports on Medicaid data and systems, OEI-09-11-00780, OEI-05-12-00610](#)
- [OIG Reports on Medicaid managed care, OEI-01-09-00550, OEI-02-11-00320](#)
- [OIG Reports on Medicaid quality of care, OEI-05-13-00690, OEI-07-12-00320](#)

## Management Challenge 2: Fighting Fraud, Waste, and Abuse in Medicare Parts A and B

### Why This Is a Challenge

To secure the future of health care for Medicare beneficiaries, the Department must be vigilant in reducing wasteful spending and promoting better health outcomes at lower costs. The Institute of Medicine estimated that 30 percent of U.S. health spending (public and private) in 2009 – roughly \$750 billion – was wasted on unnecessary services, excessive administrative costs, fraud, and other problems.<sup>27</sup> Waste in health care programs is a multidimensional problem. HHS faces challenges – and opportunities – in each of the key areas of focus addressed below.

**Reducing Improper Payments.** CMS reported an improper payment rate of 12.7 percent for Medicare fee-for-service (Parts A and B), corresponding to an estimated \$45.8 billion in improper payments in FY 2014. This measure includes payments for unnecessary services, billing or coding errors, and payments for claims that did not meet documentation or other Medicare coverage requirements. (For more information on improper payment rate measurement and reporting, see [Management Challenge 4](#).)

Challenges affect every stage of the payment process, from making the initial payment accurately (including implementing appropriate payment edits) to recovering overpayments. High Medicare improper payment rates exist for various services, including home health, skilled nursing, and evaluation and management services. Audits of hospitals have uncovered and sought to remedy improper billing and payments for myriad issues, such as incorrect billing for transfers to post-acute care and inaccurate patient diagnosis codes. Furthermore, accurate billing by hospitals for short inpatient stays versus outpatient observation stays has been an area of considerable challenge and concern. CMS relies on contractors for most of these crucial functions; however, OIG has identified deficiencies in contractor performance and in CMS's oversight of these contractors. Medicare's recent transition to a new system of diagnosis codes, the ICD-10, may bring implementation challenges and potential increases in improper billing as providers and suppliers transition to the new codes. In the lead-up to implementation of ICD-10, CMS has issued [guidance](#) providing temporary flexibility in the claims auditing and quality reporting process in response to requests from the provider community.

The Department is facing significant challenges in adjudicating provider appeals of Medicare overpayments – which primarily include Parts A and B claims – including a substantial backlog of appeals at the administrative law judge (ALJ) level (third level of appeals, administered by the Office of Medicare Hearings and Appeals); inconsistent decisions among the ALJs and between the ALJs and Qualified Independent Contractors (second level of appeals, administered by CMS); and insufficient CMS participation in the appellate process.

**Preventing and Deterring Fraud.** Curbing fraud is vital to conserving scarce health care resources and protecting beneficiaries. Fraud schemes shift over time, but certain Medicare services have been consistent targets. They include services provided by durable medical equipment (DME) suppliers, home health and hospice agencies,

<sup>27</sup> Institute of Medicine, [Best Care at Lower Cost: The Path to Continuously Learning Health Care in America](#), September 6, 2012. The Institute of Medicine report includes fraud and abuse as components of waste.

community mental health centers, clinical laboratories, ambulance transportation suppliers, outpatient therapy providers, and chiropractors. CMS's contractors play a key role in fighting Medicare fraud. However, CMS is not realizing the full potential of contractors to proactively identify fraud and address other program integrity concerns.

**Fostering Economical Payment Policies.** As a result of certain payment policies, Medicare pays significantly different amounts for the same services for similar patients in different settings. For example, Medicare pays significantly more for services performed in an outpatient hospital department than for the same services performed in an ambulatory surgical center (ASC). For low-risk patients who do not need hospital-level care at an outpatient hospital department, Medicare could save billions of dollars by paying for those services at ASC rates. In another example, Medicare could reduce expenditures by millions of dollars per year if infusion drugs administered in conjunction with DME were paid on the basis of average sales prices, as is the case with most other drugs covered by Medicare Part B.

Certain payment policies that create incentives for providers to bill for more expensive care instead of the appropriate levels of care result in billions of dollars in wasteful spending and compromised care for beneficiaries. For example, Medicare's payment policy for skilled nursing facility (SNF) beneficiaries who also need therapy give providers incentive to bill for higher levels of therapy than necessary.

### Progress in Addressing the Challenge

Overall, the Department has taken steps, including implementing many of OIG's recommendations, to combat Medicare waste, including fraud, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. The Health Care Fraud and Abuse Control Program (a joint program of the Department, CMS, OIG, and the Department of Justice (DOJ) to fight waste, fraud, and abuse in Medicare and Medicaid) returned \$7.70 for every \$1 invested. In FY 2014, OIG audits and investigations resulted in expected recoveries of \$4.9 billion in improperly spent federal health care dollars. In addition, OIG reported estimated savings of more than \$15 billion from legislative, regulatory, and administrative actions supported by OIG recommendations.

CMS has moved to improve the integrity and accuracy of billing for numerous types of services. For example, CMS implemented a provision of the *Affordable Care Act* that practitioners who certify Medicare patients as eligible for home health services must document their face-to-face encounters with those patients. CMS modified this requirement, effective January 1, 2015, and is continuing to work to improve this requirement's low rates of compliance. Additionally, CMS started a demonstration project that requires prior authorization for scooters and power wheelchairs in seven states with high incidences of fraud and improper payments, and in FY 2015 expanded this demonstration project to include an additional 12 states. CMS continues to work to address hospital billing for short inpatient stays and outpatient observation stays, which significantly affects Medicare spending, beneficiary cost-sharing, and hospital revenue.

CMS reports that it is working to identify potential alternatives to the existing methodology used to pay for therapy services under the SNF Prospective Payment System (PPS). CMS initiated the SNF PPS Payment Model Research project and reports that it is working to identify potential alternative SNF payment models for further analysis.

In connection with the International Classification of Diseases, 10th Revision (ICD-10), CMS reports that it has established an ICD-10 Coordination Center for monitoring the implementation of ICD-10, identifying and triaging issues for resolution, and responding to inquiries. It also has named an ICD-10 ombudsman to help receive and deal with provider issues.

OIG noted reductions in Medicare billing and payments for certain services and geographic areas known for fraud risks. For example, following law enforcement activities and administrative actions by CMS, billing and payments for home health services and community mental health services declined significantly in fraud hot spots. CMS also instituted temporary moratoria on the enrollment of new home health agencies and ambulance transportation suppliers in select cities and known fraud hot spots. Additionally, CMS continues to develop its Fraud Prevention System (FPS), which had a \$133 million in adjusted actual and projected savings in its third implementation year, and represented a positive return on investment of \$2.84 for every \$1 spent that was certified by OIG.

CMS reported improvements in its oversight and measurement of its contractors' performance and its follow-up on improper payment vulnerabilities that contractors identify. The Department also continues to focus on resolving the backlog of Medicare appeals by providers. CMS reports that it has taken steps toward this goal.

### What Needs To Be Done

Despite progress in key areas, more needs to be done to protect Medicare from waste, including fraud. CMS needs to better ensure that Medicare payments are accurate and appropriate. When Medicare improper payments occur, CMS needs to identify and recover them in a timely manner. CMS must also implement safeguards, as needed, to prevent recurrence. CMS relies on contractors for most of these crucial functions; therefore, ensuring effective contractor performance is essential. Finally, the Medicare appeals system needs fundamental changes to resolve appeals efficiently, effectively, and fairly. OIG has recommended numerous actions to advance these outcomes.

### Key OIG Resources

- OIG Testimony, Fraud in Medicare, March 2015
- OIG Testimony, Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse, June 2014
- OIG Testimony, Medicare Mismanagement: Oversight of the Federal Government Efforts to Recapture Misspent Funds, May 2014
- OIG Compendium of Unimplemented Recommendations, March 2015
- OIG Report, The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated, September 2015

## Management Challenge 3: The Meaningful and Secure Exchange and Use of Electronic Information and Health Information Technology

### Why This Is a Challenge

In support of its mission and operations, the Department maintains and uses expanding amounts of sensitive information. Complete, accurate, and timely data can help ensure efficient operations of the Department and its programs, as well as support proactive program oversight. Similarly, the American health care system increasingly relies on health information technology (health IT) and the electronic exchange and use of health information. Health IT, including electronic health records (EHRs), offers opportunities for improved patient care, more efficient practice management, and improved overall public health. However, the Department faces a number of significant challenges in this information-rich environment.

***Ensuring Privacy and Security of Information.*** Safeguarding privacy and ensuring data security are, and should remain, top priorities for the Department. The Department must ensure that the data it creates and maintains are protected. Equally important is the need to ensure appropriate protection of health information when considering and implementing policies related to the adoption of health IT, and the exchange, storage, and use of electronic

health information. The frequency of notable data breaches has increased significantly, and data breaches can have serious consequences for the health care industry, the Department, and those the Department serves. Those consequences can include identity theft, which, in the health care context, can negatively affect the care that patients receive and lead to wasteful, including fraudulent, spending of public funds. Frequently identified weaknesses include inadequacies in access controls, patch management, encryption of data, and Web site security vulnerabilities at the Department, health care providers, and other entities that do business with the Department. Such weaknesses could result in unauthorized access to sensitive information.

**Improving Information Flow.** To make use of the benefits of the growing amounts of data in the health care context,<sup>28</sup> data must be available, subject to appropriate privacy and security safeguards, where and when needed. However, enabling and encouraging the flow of information remains a challenge for the Department. Several factors may impede the flow of information. These include technical barriers (e.g., lack of interoperability), the complex nature of federal and state privacy and security laws, financial considerations (e.g., the cost of health IT acquisition), and behavioral issues – such as information blocking<sup>29</sup> and consumer confidence – that relate to a willingness to share information.

Improving the appropriate flow of health information is critical to the success of many delivery reform and other initiatives, including the President's Precision Medicine Initiative. Without appropriate information sharing, those who participate in the initiatives may face challenges in coordinating care and meeting performance and other goals. Impediments to information sharing can also present patient safety concerns. For example, a patient could be subjected to additional invasive testing that could have been avoided had information about prior results held by a different provider been shared. (For more information on health delivery reforms, see Management Challenge 8.)

The flow of information is also important between the Department and others, including providers. For example, data created, maintained, or transmitted using EHRs or other health IT are used to ensure correct Medicare and Medicaid payments, including value-based payments. Participants in certain initiatives also receive Departmental data for their use in improving the care they furnish. Additionally, the Department increasingly uses and shares data as part of its program operations and program integrity efforts. It is critical that, as the flow of information improves, the information is complete, accurate, timely, and appropriately protected.

**Ensuring a Return on Health IT Investments.** The Department has made significant investments in health IT. However, the Department faces challenges in ensuring that the goals associated with investing in the widespread adoption and use of EHRs and other health IT are fulfilled. In addition to the challenge of improving the flow of information, challenges to ensuring a return on the Department's investments in health IT include preventing inappropriate payments to participants who do not meet program requirements; ensuring that the beneficial characteristics of EHRs, including efficiency and ease of storage and access, are not used as tools for fraud; and ensuring that patient safety benefits are realized. When addressing these challenges, the Department must ensure coordination among internal agencies, as well as other federal partners, with overlapping responsibility for various aspects of health IT to avoid potential gaps in policy and oversight that could undermine the promise of the investments.

<sup>28</sup> Sources of relevant health care data are ever increasing, particularly as the Internet of Things continues to expand. For more information about the Internet of Things, particularly related privacy and security issues, see FTC's Staff Report, Internet of Things: Privacy and Security in a Connected World, January 2015. See also, Federal Bureau of Investigation Public Services Announcement, Internet of Things Poses Opportunities for Cyber Crime, September 10, 2015.

<sup>29</sup> For more information on the topic of information blocking, see ONC's Report to Congress, Report on Health Information Blocking, April 2015.

## Progress in Addressing the Challenge

The Department has made progress with respect to privacy and security of its systems and information. Like others in the federal government, the Department has participated in the U.S. Chief Information Officer's 30-day Cybersecurity Sprint, which aims to "further improve federal cybersecurity and protect systems against . . . evolving threats."

The Department has made great strides in developing a nationwide health IT infrastructure that supports the appropriate flow of information. As of September 2015, more than 548,000 eligible professionals, eligible hospitals, and critical access hospitals (CAH), are actively registered in the EHR incentive programs.<sup>30</sup> Additionally, the Office of the National Coordinator (ONC) recently issued \$38 million in grants to encourage better information exchange for care coordination and population health.

Further, the Department's participation in the Healthcare Fraud Prevention Partnership (HFPP) has improved the flow of information to address program integrity issues. The HFPP, a public-private partnership, brings interested parties – including private insurers, law enforcement agencies, and others – together to share and use data and analytic tools to proactively address health care fraud.

The Department has continued to oversee the EHR incentive programs and has made a concerted effort to advance the national conversation about important health IT issues to ensure that the potential benefits of health IT investments are realized. Last year, ONC issued a document entitled "Connecting Health and Care for the Nation: A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure" (10-Year Vision Paper), which describes plans to expand the sharing of information for health beyond EHRs and identifies privacy and security protections for health information as a building block for a nationwide interoperable health information infrastructure. More recently, ONC issued a document entitled "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0," which supports the vision laid out in the 10-Year Vision Paper. ONC has also issued an information-blocking report to Congress, a Health IT Safety Center Roadmap, and an updated Federal Health IT Strategic Plan for 2015–2020.

## What Needs To Be Done

Threats to information privacy and security are evolving, and the Department must remain vigilant. While the Department has made progress with respect to protecting its own information, as highlighted in OIG work and a recent Congressional Report, more remains to be done. The Department also must use available policy levers to address health IT privacy and security issues, such as through the EHR incentive programs. OIG work will continue to focus on HHS systems' privacy and security to support the Department's efforts to mitigate the risk of unauthorized access to its sensitive information. OIG work will also focus on privacy and security issues in the regulated community and on the related agencies to address concerns about similar risks for health information. Future work may consider privacy and security issues that arise from the continuing expansion of the Internet of Things, such as connected medical devices.

To fully realize the value of health IT investments – which included, as of September 2015, over \$31 billion through the EHR incentive programs – and achieve the goal of a learning health system identified in the 10-Year Vision Paper, the Department must do more to improve the flow of information, subject to appropriate privacy and security safeguards.

<sup>30</sup> CMS, "State Breakdown of Registration by Medicaid and Medicare Providers through September 30, 2015," September 2015.

Finally, given the magnitude of the investment in EHRs and other health IT programs, it will become increasingly important to measure the extent to which EHRs and health IT have achieved the Department's goals, which include improved health care and lower costs. As the Department progresses through the development and implementation of meaningful use stages and looks to implement the meaningful use portion of the Merit-based Incentive Payment System created in the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), it should continue to consider feedback from stakeholders to ensure that adopted policies advance the Nation toward the Department's stated goals, while appropriately reflecting the changing health IT landscape and balancing privacy and security considerations. Additional guidance and technical assistance should be issued to address adoption, meaningful use, interoperability barriers, and program integrity safeguards. It is also essential that privacy, security, and fraud prevention remain at the forefront of the Department's, ONC's, and CMS's health IT efforts. Ongoing OIG work is examining the accuracy of Medicare and Medicaid EHR incentive payments for meaningful use. Future work may examine health IT interoperability across providers (including those participating in accountable care organizations), across HHS, and between providers and patients, as well as examine outcomes from health IT investments.

### Key OIG Resources

- OIG Reports on EHR Incentive Program Oversight, [A-06-13-00047](#); [OEI-09-11-00380](#); [A-06-12-00041](#); [OEI-05-11-00250](#); [OEI-05-11-00080](#)
- OIG Reports on EHR program integrity, [OEI-01-11-00570](#), [OEI-01-11-00571](#)
- OIG Report, [CMS Response to Breaches and Medical Identity Theft](#), October 2012
- OIG Summary Report, [Information Technology Infrastructure and Operations Office Had Inadequate Information Security Controls](#), April 2015
- OIG Reports on hospital IT security, including HIPAA Security Rule Oversight, [June 2011](#), [OEI-09-10-00510](#), and [OEI-09-10-00511](#)

## Management Challenge 4: Administration of Grants, Contracts, and Financial and Administrative Management Systems

### Why This Is a Challenge

HHS is the largest grant-making organization and third-largest contracting agency in the federal government, with \$402 billion and \$21 billion awarded, respectively, in FY 2014. The *Affordable Care Act* provided additional grant and contract funding, adding to the Department's management and oversight responsibilities. Responsible stewardship of these program dollars is vital, and operating a financial management and administrative infrastructure that employs appropriate safeguards to minimize risk and protect resources remains a challenge for the Department.

**Grants and Contracts Management.** Across the Department, vulnerabilities have been identified in HHS grants, demonstrating the need for purposeful and consistent federal oversight. Awarding agencies lack a systematic method of and timing for sharing grantee risk information; sharing occurs infrequently; and oversight of grantee progress during the life of the grant needs improvement. Many grantees lack the robust financial management systems required to provide effective accountability for federal funds. For example, a community health center receiving *Affordable Care Act* grant assistance was not providing the services as described in its grant application and was unable to accurately account for how HHS funds were spent. Recent OIG investigations of HHS grantees reveal similar vulnerabilities in grants management. For example, in June 2014, four former officials of the Blackfeet Tribe's Po'ka Project, a multimillion-dollar HHS-funded effort to address the needs of troubled youth on the reservation, were convicted of fraud, embezzlement, and conspiracy and sentenced in federal court.



Previously identified weaknesses in the oversight of grantees, including late or absent financial reports and insufficient documentation on salaries and indirect costs, present challenges to the Department's implementation of the Office of Management and Budget's (OMB) Uniform Guidance.<sup>31</sup> Another challenge is implementation of the *DATA Act* that establishes governmentwide financial data standards related to expenditures of federal grants, contracts, and loans.

HHS is the second-largest payer under the Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) programs, awarding \$680.7 million and \$96.6 million, respectively, in such grants and contracts in FY 2014. Three significant issues exist with the programs: awardees who appeared not to meet eligibility requirements, inconsistent collection of information needed to evaluate commercialization success, and failures to check consistently for duplicative funding within the Department and across other agencies.

Given the high dollar amount and complexity of contracts, weaknesses in Department monitoring of the corrective actions taken, processes, oversight, and management is a concern. Oversight vulnerabilities have been identified through a range of issues across Departmental programs. For example, OIG has raised concerns about acquisition planning and procurement, contract monitoring, and payments to contractors related to the federal health insurance marketplaces operated by CMS. OIG has also identified weaknesses in CMS's oversight and performance measurement for its benefit integrity contractors. (For more information on specific contract management concerns, see [Management Challenges 2](#) and [7](#).)

**Financial Statement Audits.** An audit of the Department's grant and contract systems, which are responsible for processing, awarding, and monitoring grants and contracts, uncovered multiple deficiencies in effective system controls. Deficiencies were related to segregation of duties, configuration management, and access to financial systems. The deficiencies represent a material weakness in internal controls – affecting the Department's ability to accurately manage financial information.

The financial statement audit also revealed challenges the Department continues to face in addressing violations of certain provisions of the *Anti-Deficiency Act* (ADA). These ADA violations highlight weaknesses in an agency's control over budgetary resources. Prior OIG audits of the National Institutes of Health (NIH) revealed ADA violations. The Department followed up with GAO regarding the violations. OIG will be doing a status report to assess and summarize the remedial actions taken by the Department to address the ADA violations.

**Improper Payments.** Improper payments cost federal programs billions of dollars annually. In FY 2014, the Department reported improper payments totaling almost \$78.4 billion overall. Pursuant to the *Improper Payments Information Act of 2002* (IPIA), as amended, federal agencies are required to provide uniform, annual reporting on improper payments and their efforts to reduce them. In OIG's most recent audit of the Department's IPIA reporting, we found that the Department did not meet all IPIA requirements, including reporting an improper payment rate for the Temporary Assistance for Needy Families (TANF) program and performing a risk assessment of payments to employees and charge card payments. HHS asserts that it does not have the statutory authority to collect from states the data that is necessary for the calculation of a TANF improper payment rate.

### Progress in Addressing the Challenge

The Department has worked to strengthen its grants and contracts program integrity efforts. New grant regulations were published at 45 CFR Part 75, implementing OMB's Uniform Guidance requirements. Pursuant to those rules, the Assistant Secretary for Financial Resources (ASFR) is implementing a single audit resolution tracking system -- scheduled for completion by September 30, 2017. These rules also create a 270-day

<sup>31</sup> Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (commonly referred to as the Uniform Guidance).



requirement to ensure all grant close out activities are complete. The Department is also serving as the governmentwide lead to identify the standardized data needed to meet the *DATA Act* requirements and has developed a Departmental implementation strategy to ensure adoption of approved data standards into business policies, processes, and systems.

The Department proposed an update to the HHS Acquisition Regulation (HHSAR) in March 2015 to supplement the Federal Acquisition Regulation. The HHSAR provides additional policy and procedural guidance to foster financial integrity and accountability across the acquisition lifecycle from the concept of need through contract close out. Additionally, HHS issued the Acquisition Strategy Directives in March 2015 and Acquisition Plan Directives in April 2015 which articulated the value and importance of HHS program offices adopting and implementing the acquisition lifecycle framework as a means to ensure business process/practices and mission/program needs drive requirements, and ensure the most appropriate vehicle is utilized to deliver critical results.

With respect to ADA violations related to systemic contract funding problems, the Department continues to provide its contracting workforce with an online reference tool for contract funding, formation, and appropriations law compliance. Further, the Department released a major update to its internal grants policies, featuring enhanced guidance on grants closeout, suspension and debarment, grants systems, and grants payments.

The Department has made efforts to assess grant program performance and improve grant and contract oversight. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has improved outcome measurements for its largest program, the Substance Abuse Prevention and Treatment Block Grant. The Indian Health Service (IHS) and OIG partnered to provide training on using single audit reports to improve oversight of tribal health care funds. Furthermore, the Department and OIG sponsored training for grants and contracts officers on identifying and reporting potential fraud, waste, and abuse across all programs, including the SBIR/STTR programs, and OIG has encouraged contractors to self-report contract fraud and overpayments.

The Department has increased its use of suspension and debarment authorities, resulting in an increase from 8 debarments and 8 suspensions in FY 2013 to 32 debarments and 7 suspensions in FY 2014 – preventing offenders from receiving federal funding.

The Department has taken corrective actions to resolve the IT-related deficiencies reported in the Agency Financial Report. The impact of this effort will be assessed during the FY 2015 audit of these systems.

With respect to IPIA, the Department has stated in its comments on our IPIA-compliance audit report pertaining to the Department's FY 2013 AFR that it would submit a legislative proposal to Congress that would allow for a TANF error rate measurement. The Department, however, did not do so. Instead, the Department has reported that it submitted legislative proposals to Congress to improve TANF's program integrity. Specifically, the Department noted that ACF's FYs 2015 and 2016 Budget requests for TANF included \$10 million for program improvement initiatives, including technical assistance on strengthening state program integrity efforts. The requests also proposed to prohibit the use of non-governmental third-party expenditures in meeting state maintenance-of-effort (MOE) requirements, and limiting the expenditure of TANF and MOE funds to benefits and services to needy families. The Department asserts that both of these proposed legislative changes would strengthen state accountability to the purposes of the TANF statute. CMS reports that it has prioritized closing out contracts. Since February 1, 2014, CMS closed 2,077 contracts with an obligated value of \$1.3 billion and de-obligated \$29.95 million. In October 2014, CMS implemented a goal of closing out approximately 20 percent – or 2,250 – overdue contracts per year.

## What Needs To Be Done

The Department needs to take more aggressive action to identify poorly performing grantees and those at risk of mispending federal dollars and either provide increased technical assistance and monitoring or prevent them from continuing to receive grant funds. Sustained focus is needed to monitor and address vulnerabilities, and the Department must continue diligent efforts to ensure that recipients use funds according to the award terms and consistent with the law. The Department has improved its contractor performance evaluation monitoring but is still underperforming compared to other government agencies.

The Operating Divisions (OpDiv) need to increase their monitoring efforts, including implementing program integrity initiatives, such as evaluating and mitigating risks, identifying and addressing cross-cutting issues; resolving grantee audit findings; and sharing best practices across the Department. In accordance with the new Uniform Guidance, the Department must implement processes to ensure that grantees have appropriate internal controls, including improved use of single audit reports throughout the grant cycle to ensure proper stewardship of funds. The Department will need to develop tracking and monitoring mechanisms for audit findings and the audit resolution process to effectively carry out this responsibility. The Department must also prepare for implementation of *DATA Act* requirements.

The Department needs to develop an improper-payment estimate for TANF and submit a legislative proposal to Congress to require state participation in such a measurement. In addition, the Department needs to meet improper-payment reduction targets, and reduce improper payments to less than 10 percent for all programs. The Department needs to conduct thorough root cause analyses of significant improper payments and develop robust corrective action plans that target identified causes. The Department also needs to conduct a risk assessment of payments made to employees and charge cards. The Department should resolve all financial control weaknesses identified by OIG, GAO, and other internal and external auditors.

The Department and OIG should continue to provide training on identifying and pursuing misconduct in grants and contracts. Grant and contract officers should more actively coordinate with and refer potential fraud to OIG for investigation. The Department also needs to continue to refine its suspension and debarment procedures by streamlining the referral and decision process, to continue providing training and decrease the processing time of referrals. Moreover, the Department needs to implement a program to actively pursue fraud under the *Program Fraud Civil Remedies Act* (PFCRA).

## Key OIG Resources

- OIG Report, [U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did Not Fully Comply for Fiscal Year 2014](#), May 2015
- OIG Reports on grant oversight, [OEI-04-12-00160](#), [OEI-04-11-00530](#), [OEI-07-12-00110](#), [OEI-07-11-00190](#), [A-03-14-03304](#)

## Management Challenge 5: Ensuring Appropriate Use of Prescription Drugs

### Why This Is a Challenge

CMS provides prescription drug coverage for 41 million Medicare Part D (Part D) and 71 million Medicaid beneficiaries. Part D is the fastest growing component of the Medicare program. Since its inception in 2006, spending for Part D has more than doubled to \$121 billion in 2014. Medicaid expenditures for prescription drugs are also increasing, influenced by Medicaid expansion and rising specialty drug costs. In 2014, Medicaid expenditures exceeded \$44 billion and Medicaid beneficiaries in states that expanded the program filled

25 percent more prescriptions, compared with a 3 percent increase in non-expansion states.<sup>32</sup> The Department's oversight of its prescription drug programs faces numerous challenges affecting beneficiary and community safety and the integrity of the benefit itself.

**Oversight.** Ensuring the integrity of programs as expansive as Part D and Medicaid requires coordinated, constant, and proactive efforts. In Part D, CMS contracts with plan sponsors, which are responsible for paying claims, monitoring billing patterns, and establishing compliance plans. CMS also contracts with the Medicare Drug Integrity Contractor (MEDIC) to detect and prevent fraud, waste, and abuse in Part D. CMS oversees the plan sponsors and the MEDIC, defines their requirements for carrying out program integrity functions, and monitors their performance. Weaknesses continue to exist in the use of data to identify vulnerabilities as well as in the oversight by each of the three key players. For example, CMS does not require plan sponsors to report information on fraud and most have chosen not to voluntarily report. (For more information on Medicaid's oversight challenges, see [Management Challenge 1.](#))

**Drug Abuse and Diversion.** The abuse and diversion of prescription drugs is an ongoing problem. As of May 2015, OIG has 540 pending complaints and cases involving Medicare and Medicaid prescription drug fraud, a 134 percent increase in the last 5 years. Pharmaceutical manufacturers and pharmacies accounted for more than 60 percent of Medicaid Fraud Control Units' cases that resulted in civil settlements and judgments in 2014. The Centers for Disease Control and Prevention (CDC) characterizes prescription drug abuse as an epidemic, reaching virtually all demographics and geographic locations. Drug diversion is the transfer of legitimate prescription drugs for unlawful purposes. The diversion of controlled substances is of particular concern because of its severe health risk and potential for abuse. In 2012, over 700,000 inpatient hospital stays were related to the overuse of opioids.

The diversion of noncontrolled substances is also a concern because these drugs are becoming more common in schemes that defraud Medicare and Medicaid. Schemes include billing for drugs that are not dispensed, combining prescribed drugs with opioids to create an enhanced euphoria, and illegal dispensing of expired or adulterated drugs. These schemes increasingly involve criminal networks ranging from informally connected street traffickers to complex criminal enterprises comprised of health care professionals, pharmacies, marketing companies, and even program beneficiaries. Criminal networks and others target brand-name, high-cost medications, including respiratory, HIV, and anti-psychotic medications.

**Questionable and Inappropriate Utilization.** The responsibility of overseeing prescription drugs also involves ensuring that safe and high-quality care is provided to seniors and children. Serious concerns surrounding the overprescribing of drugs exist. For example, Medicare spending for commonly abused opioids has grown faster than spending for all Part D drugs. Additionally, quality-of-care concerns were identified with the prescription drug treatment of children enrolled in Medicaid who have mental health conditions. (For more information on ensuring Medicaid quality of care, see [Management Challenge 1.](#))

Several operating divisions within the Department are responsible for programs related to the safety and efficacy of drugs, drug abuse prevention and treatment, and the safety and quality of health care – including care involving drugs, biologics, and other therapies. Effectively coordinating all Department efforts and prioritizing initiatives are key to combating this complex epidemic. (For more information on challenges for the Food and Drug Administration (FDA) and Medicaid, see [Management Challenges 10](#) and [1.](#))

<sup>32</sup>IMS Institute for Healthcare Informatics, *Medicine Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014*, April 2015.

## Progress in Addressing the Challenge

CMS has taken steps to improve data coordination among the key players tasked with safeguarding Part D. Specifically, CMS has begun sharing plan sponsors' voluntarily reported fraud data with the MEDIC and has increased data sharing between plans. CMS is working to enroll over 400,000 prescribers of Part D drugs, addressing an OIG recommendation that CMS require Part D sponsors to verify prescribers' authority. These prescribers will be subject to risk-based screening requirements, and plan sponsors will be better able to deny Part D claims for drugs ordered by ineligible prescribers.

CMS is also taking steps to prevent pharmacy billing fraud and overutilization of prescription drugs. CMS regularly monitors pharmacy billing patterns and collaborates with Part D sponsors to perform audits or take other appropriate actions on high-risk pharmacies. CMS works with plan sponsors to prevent overutilization of certain prescribed medications and share information about beneficiaries that may over use prescription drugs. In April 2015, CMS launched a Web-based tool to allow CMS, law enforcement, and plan sponsors to share information and coordinate actions against high-risk pharmacies.

The Department has taken actions to restrict the manufacture, possession, or use of potentially dangerous controlled substances. The Food and Drug Administration (FDA) is working to reduce the abuse of opioids by encouraging formulations that make it more difficult to tamper with these products. Additionally, through coordination with the Drug Enforcement Administration (DEA), access to opioids is now better controlled because hydrocodone-combination products have been moved from Schedule III to the more restrictive Schedule II. Many state Medicaid programs have reported savings linked to implementing lock-in programs, which involves restricting certain beneficiaries to a limited number of pharmacies or prescribers. Additional benefits to lock-in programs include more appropriate beneficiary drug utilization and prevention of drug abuse and diversion. Additionally, CDC is developing guidelines to help primary care physicians improve the way they prescribe opioids to treat chronic pain, and CMS has established a new Medicaid initiative to undertake improvements in the delivery of care to beneficiaries with substance use disorder.

## What Needs To Be Done

Despite progress in key areas, further actions are needed to achieve effective oversight. CMS needs to do more to monitor plan sponsors' fraud detection and compliance programs. For example, CMS should require plan sponsors to report the number of instances of probable fraud, waste, and abuse that they identify, and the actions they took to address them. Collecting and sharing this data would increase each players' ability to identify and address program vulnerabilities. Additionally, CMS should improve existing safeguards to prevent improper payments in Part D and its ability to recoup those payments when identified. When the MEDIC identifies inappropriate payments there are no established procedures to recommend recoupment other than referrals to law enforcement. While CMS does require plan sponsors to return overpayments that they self-identify, CMS has no mechanism to recover inappropriate payments identified by the MEDIC during its investigations.

The Department should continue to prioritize and coordinate efforts to reduce opioid misuse and abuse. For example, CMS and plan sponsors should monitor beneficiary use of a wider range of drugs susceptible to abuse than they do now. Also, more needs to be done to effectively deal with beneficiaries who may be abusing the program or inflicting harm on themselves by overusing drugs. This could be addressed by implementing a Medicare lock-in policy, which would require a legislative change to CMS's authority.

## Key OIG Resources

- OIG Portfolio, [Ensuring the Integrity of Medicare Part D](#), June 2015

- [OIG Report, \*Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns\*, March 2015](#)
- [OIG Report, \*Questionable Billing and Geographic Hotspots Point to Potential Fraud and Abuse in Medicare Part D\*, June 2015](#)
- [OIG Report, \*Medicaid Fraud Control Units Fiscal Year 2014 Annual Report\*, April 2015](#)

## Management Challenge 6: Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care

### Why This Is a Challenge

As Americans continue to live longer and with more chronic medical conditions, the Department must ensure that beneficiaries receive high-quality nursing home, hospice, and home- and community-based services (HCBS), including personal care services (PCS). Nursing home and HCBS programs provide ongoing assistance with daily living, as well as care for those who need temporary help recuperating from hospital stays or other acute care. Hospice care provides comfort for terminally ill beneficiaries and supports family and other caregivers.

***Nursing Home and Hospice Care.*** Problems with nursing home and hospice care continue to be identified. Concerns raised include the frequency and severity of preventable adverse events because of substandard nursing home care, limited compliance with federal regulations for reporting abuse and neglect, lack of monitoring of nursing homes' resident hospitalization rates, failure to correct deficiencies identified during the survey process, and employment of caregivers who do not meet relevant licensure requirements. Additional concerns regarding hospice care include inadequate oversight of certification surveys and hospice-worker licensure requirements and fraudulent hospice enrollments undertaken without beneficiary consent.

***Home- and Community-Based Services.*** HCBS programs serve several targeted populations, including people with mental illness, or physical, cognitive, or developmental disabilities. HCBS programs help beneficiaries avoid costly and disruptive facility-based care. These programs help promote beneficiary choice and preferences, but persistent payment, compliance, and quality vulnerabilities continue. Medicaid is the primary payer for PCS, a critical component of HCBS. Without effective PCS, the HCBS goals of keeping beneficiaries out of institutions cannot be achieved. Of significant note are vulnerabilities specific to PCS, such as delivery in private settings in which care may be harder to observe and oversee.

### Progress in Addressing the Challenge

The Department continues efforts to improve the quality of nursing home, hospice, and HCBS programs, including PCS. CMS developed the CMS Adverse Drug Event Trigger Tool for use by nursing homes and state surveyors to improve medication safety and reduce medication-related adverse events. In July 2015, the Department published a proposed rule on Reform of Requirements for Long-Term Care Facilities. Along with other quality improvement initiatives, the proposed rule would implement section 6102 of the *Affordable Care Act*, which requires each nursing facility to have an operational compliance and ethics program that effectively promotes quality of care.

CMS made the following improvements to the *Five Star Quality Rating System* posted on the *Nursing Home Compare* Web site to improve beneficiaries' and consumers' ability to determine meaningful differences between nursing homes, incentivize increased quality, and ensure the accuracy of the information posted: added two Quality Measures (QM) for antipsychotic medication use; raised the threshold for nursing homes to achieve a high

rating on all measures in the QM dimension of the Five Star System; and expanded focused surveys nationwide to assess coding practices and its relationship to resident care in nursing homes to improve the accuracy of the QMs.

In August 2015, CMS finalized a rule for the PPS and Consolidated Billing for SNFs for FY 2016. This rule implemented section 6106 of the *Affordable Care Act*, which allows for greater oversight and increased accuracy for reporting of nursing home staffing on the *Nursing Home Compare* website and in the *Five Star Quality Rating System*. Also, this rule specified a SNF all-cause all-condition hospital readmission measure and adopts that measure for a new SNF Value-Based Purchasing (VBP) Program. Additionally, the rule will implement a new quality reporting program (QRP) for SNFs that authorizes CMS to reduce payments to nursing homes that do not report certain resident assessment items and establishes the plan to standardize certain elements of assessment tools and quality measures across post-acute care settings.

In July 2015, CMS published a proposed rule to improve the quality of nursing home care that updates Medicare requirements for long-term-care facilities. This proposed rule also would implement provisions of the *Affordable Care Act*, including requirements for facilities to implement a Quality Assurance and Performance Improvement (QAPI) program that would ensure that facilities continuously identify and correct quality deficiencies and promote and sustain performance improvement. Additional provisions would implement requirements for a Compliance and Ethics program, requirements for dementia and abuse prevention training, and requirements for reporting suspected crimes.

The Department continues efforts to improve access to hospice care. Traditionally, to qualify for hospice services, Medicare required beneficiaries to forego curative services. CMS, through the Medicare Care Choices model, is now testing allowing beneficiaries to receive hospice care to manage discomfort and receive end-of-life counseling while still allowing Medicare payment for treatments aimed at curing the underlying terminal illness. CMS has also taken steps to encourage patients and their physicians to discuss end-of-life issues to improve patients' quality of life and increase the likelihood that the end-of-life care the patients ultimately receive conforms to their informed wishes. As access improves, the Department must continue efforts to ensure that the quality of hospice care delivered to beneficiaries who select hospice meets quality standards.

Federal agencies, including OIG, DOJ, and CMS, continue to pursue enforcement actions against nursing homes, hospices, and HCBS providers, including PCS providers that render substandard care. In the past year, OIG launched an initiative to combat hospice fraud in regions identified as areas of particular concern. In the summer of 2015, OIG completed a national health care fraud takedown that included arrests of several Medicaid providers accused of committing HCBS fraud. CMS and OIG work closely with law enforcement partners at DOJ and through the federal Elder Justice Interagency Working Group to promote better care for older adults and to prosecute providers accused of abuse or neglect. State Medicaid Fraud Control Units (MFCU) devote substantial resources to the investigation and prosecution of abuse and neglect.

In addition to the Department's efforts to improve quality of care, OIG invests substantial efforts in helping providers improve. OIG has developed an innovative quality-oriented corporate integrity agreement process to work with nursing home providers so they may better serve beneficiaries. OIG has placed nearly 40 nursing home companies (covering more than 900 facilities) under corporate integrity agreements that include quality-monitoring provisions designed to ensure that beneficiaries receive the care they deserve.

Ensuring high-quality home- and community-based services and enabling beneficiaries to avoid institutionalization, relies heavily on appropriate personal care services. CMS is in the second year of a four-year cycle of grants to nine qualified states to test quality measurement tools and demonstrate the use of electronic tools in Medicaid community-based long-term services and supports. These tools are designed to establish standardized interoperable data sets for HCBS plans and assessment items measure the experience of care for beneficiaries and

test the use of personal health records. An experience-of-care tool has been designed, tested and is in the final stages of certification. The Department entered into a contract last year with the National Quality Forum and began work on the development of a national quality measure set for home- and community-based services. Domains of measures have been made and an environmental scan started to identify key measures as well as gaps in measures for domains that might not have been developed to date.

### What Needs To Be Done

The Department should continue to prioritize quality of care in nursing homes and hospices as well as the care rendered as HCBS, with particular focus on PCS. The Department should monitor how often nursing home residents are hospitalized and develop resources that can be used to help nursing home staff reduce the incidence of adverse events in nursing homes. In addition, the Department should improve internal controls and offer better guidance and training for surveyors to ensure that nursing homes with recorded quality and safety issues correct their deficiencies. CMS should improve coordination with state agencies to ensure that care providers meet relevant licensure requirements. The Department should seek to link payments for services to meeting quality-of-care requirements and work with OIG to hold accountable the providers that have rendered substandard care, thereby preventing additional harm to vulnerable beneficiaries.

Lastly, the Department should ensure the integrity of Medicaid-funded PCS by establishing minimum federal qualification standards for providers based on needs of the individual being served; improving CMS's and states' ability to monitor billing and care quality; and issuing operational guidance for claims documentation, beneficiary assessments, person-centered plans of care, and supervision of personal care attendants when hired by an agency. For self-directed programs in which a beneficiary directs his/her own PCS, CMS and the states should improve oversight of controls to ensure individual health and welfare and financial integrity. The Department should also issue guidance to states regarding adequate prepayment controls and help states access data necessary to identify overpayments.

### Key OIG Resources

- OIG Report, [Personal Care Services: Trends, Vulnerabilities and Recommendations for Improvement – A Portfolio](#), November 2012
- OIG Report, [The Medicare Payment System for Skilled Nursing Facilities Needs to Be Reevaluated](#), September 2015
- OIG Reports on hospice quality of care, [OEI-02-14-00070](#), [A-02-11-01024](#)
- OIG Reports on home health quality of care, [OEI-01-12-00390](#), [OEI-07-14-00130](#)
- OIG Reports on nursing home quality of care, [OEI-07-13-00010](#), [OEI-02-13-00611](#), [A-09-13-02039](#), [OEI-06-11-00370](#)

## Management Challenge 7: Implementing, Operating, and Overseeing the Health Insurance Marketplaces

### Why This Is a Challenge

The health insurance marketplaces (marketplaces), also known as health insurance exchanges, are critical components of the health care reforms enacted through the *Affordable Care Act*. Implementation, operation, and oversight of the marketplaces were among the most significant challenges for the Department in FYs 2014 and 2015 and will continue to present a top management and performance challenge in FY 2016.



The Department must ensure effective communication and coordination between and among all internal and external parties with marketplace responsibilities, including within HHS and with contractors, issuers, and partners in state and federal government. Effective coordination with the Internal Revenue Service (IRS) is particularly important for sound administration of the premium tax credit program. In addition, CMS needs to ensure that state marketplaces comply with federal requirements and provide accurate, timely data used for federal payments. Further, CMS must take appropriate steps to promote compliance by Qualified Health Plans (QHP) with federal requirements, including network adequacy and nondiscrimination requirements. Key focus areas for the federal and state marketplaces include:

**Payments.** Ensuring sound expenditure of taxpayer funds for insurance affordability and other marketplace purposes poses a substantial management challenge, especially given the continued use of interim solutions and manual systems. For example, CMS's internal controls did not effectively ensure the accuracy of nearly \$2.8 billion in advance premium tax credits and cost-sharing reductions. CMS must improve its financial systems to ensure accurate and timely initial payments and reconciliations of these payments. CMS must also prioritize effective management of the risk corridor, reinsurance, and risk adjustment programs. CMS must validate information received from issuers to ensure that it is timely, complete, and accurate for payment purposes. In addition, CMS must ensure the correct use of federal establishment grant funds by state marketplaces. (For general information about challenges associated with grants management and contract administration, see [Management Challenge 4](#).)

**Eligibility.** Accurate eligibility determinations are critical. During the first open enrollment period, not all internal controls at certain marketplaces were effective in ensuring that individuals were properly determined eligible for QHPs, advance premium tax credits, and cost-sharing reductions. CMS reported a large number of unresolved inconsistencies in which applicants' self-reported data did not match other data sources. Effective internal controls and timely and accurate resolution of inconsistencies are critical to ensure that eligible consumers receive appropriate benefits and that ineligible individuals are not enrolled.

**Management and Administration.** Management and administration of the marketplaces requires, among other things, clear leadership, disciplined operations, and effective strategies and communication. OIG has raised concerns with, among other issues, CMS's acquisition planning and procurement, contract monitoring, and administration of payments for marketplace contracts. The Department also must ensure, to the greatest extent possible, that the government obtains specified products and services from its contractors on time and within budget.

**Security.** Protecting and ensuring the confidentiality and integrity of consumers' sensitive personal information and marketplace information systems is paramount. Effective operation of the marketplaces requires rapid, accurate, and secure integration of data from numerous federal and state sources, issuers, and consumers. The Department must vigilantly guard against intrusions and continuously assess and improve the security of marketplace-related systems, including, among others, the Data Services Hub and the Multidimensional Insurance Data Analytics System (MIDAS), a data warehouse and repository. (For more information on privacy and security, see [Management Challenge 3](#).)

### Progress in Addressing the Challenge

The Department has reported improvement in the operations of the federal marketplace. Following the initial launch of [www.HealthCare.gov](http://www.HealthCare.gov), CMS implemented several core management principles that enabled the organization to recover the Web site and improve agency management and culture. In addition, CMS has reported progress in marketplace operations, including publishing additional guidance regarding the use of federal establishment grant funds, implementing parallel processing and multiple levels of review of financial assistance payments information, working to develop a strategic and unified view of marketplace procurement and costs, and



developing of a strategy to improve marketplace program integrity. CMS has also reported regular communications with the IRS to validate payment information and the provision of technical and other support to the state marketplaces.

### What Needs To Be Done

The Department must continue to improve the federal marketplace, particularly the eligibility, administrative, and financial management functions. CMS must ensure that all pathways for enrollment operate with integrity and that consumers' personal information is secure. Vigilant monitoring and testing and rapid mitigation of identified vulnerabilities are essential. Attention must be paid to sound operation of financial assistance and the risk corridor, reinsurance, and risk-adjustment programs. CMS must ensure that consumers and issuers receive accurate marketplace information, including information relevant for tax purposes, such as Form 1095A tax forms. Furthermore, marketplaces must continue to protect personally identifiable information and strengthen security controls.

CMS must continue to work with its state partners to improve state marketplace operations and to ensure compliance with federal requirements for marketplaces and QHPs. CMS must monitor for and address fraud, waste, and abuse risks in marketplace programs. CMS must respond quickly and effectively to fraud that is detected, working with partners at the federal and state level to hold those involved accountable.

### Key OIG Resources

OIG has a broad portfolio of reviews examining various aspects of marketplace operations. For a complete list of these OIG reports, as well as OIG's Health Reform Oversight Plan, please see the [Affordable Care Act Reviews](#) section on the OIG Web site.

## Management Challenge 8: Reforming Delivery and Payment in Health Care Programs

### Why This Is a Challenge

As recently as 2011, almost none of the \$558 billion spent on traditional Medicare was paid through alternative payment models (APM). Instead, CMS paid the majority of claims through the fee-for-service (FFS) system. The incentives created by the fee-for-service (FFS) system—which pays for health care on the basis of the volume of items or services furnished—have been linked to wasteful spending in health care, including unnecessary utilization and fragmented, poor quality care.

In January 2015, Secretary Burwell announced goals to foster better care, smarter spending, and healthier people and propel a transition to new models in Medicare. The ambitious goals are twofold. First, HHS aspires to tie 30 percent of traditional Medicare payments to APMs by the end of 2016, including bundled payment arrangements, and 50 percent of payments by the end of 2018. Second, HHS set a broader goal of tying 85 percent of traditional Medicare payments to quality or value – including not only APMs but also quality-based adjustments to fee-for-service payments – by 2016 and 90 percent by 2018. HHS is working with state Medicaid programs and private payers, including Medicare Advantage plans and others, to make comparable reforms for their providers and beneficiaries.

Reforms under *Affordable Care Act*, MACRA, and other statutes are embedding multiple new payment and delivery models into Medicare, requiring concurrent, sustained, and multifaceted efforts at planning and implementation. New models touch on virtually every aspect of the Medicare program – including, for example, hospital, physician,

home health, dialysis, and post-acute care payment – and experiment with a variety of payment structures, including shared savings, episode-based payments, population-based payments, and capitation. In addition, CMS must implement a new market-driven payment system for laboratory services beginning in 2017.

CMS must establish policy, infrastructure, data systems, and oversight mechanisms to successfully implement these substantial changes. The Center for Medicare and Medicaid Innovation (CMMI) has a 10-year budget of \$10 billion dollars; the Department must ensure that Medicare realizes a return on the government's substantial investment in designing, testing, and implementing new models. Perhaps equally challenging is ensuring that models are viable in light of providers' substantial investments in infrastructure and care redesign.

Payment and delivery reforms are not exclusive to fee-for-service Medicare. The Department is promoting new models for Medicare Advantage (Part C). Medicare Advantage is a growing program with potential for increased efficiency and quality through better coordinated care, aligned incentives, and performance measurement. OIG work has identified challenges in the Medicare Advantage program with respect to use of data, payment accuracy, and program integrity, including addressing vulnerabilities at both the plan and provider levels. Ensuring a sound Medicare Advantage program is essential to enabling this program to meet its intended cost and quality goals. (For more information on improving the effectiveness of Medicaid managed care, please see [Management Challenge 1](#).)

### Progress in Addressing the Challenge

The Department reports that an estimated 20 percent of Medicare fee-for-service payments had shifted to APMs by the end of 2014. On its Web site, CMS is compiling a steady stream of early results from and evaluations of new programs and models. Recently, for example, [CMS reported](#) that Medicare accountable care organization (ACO) programs generated total program savings of more than \$411 million for Medicare in 2014 and that ACOs qualified for shared savings payments of more than \$422 million. CMS further reported that nine of 17 participants in the Independence at Home (medical home) Demonstration met the requirements for practice incentive payments in the model's first performance year.

CMS reported in its second biannual report to Congress that it had undertaken 22 models, including accountable care and bundled payment models, with more in development. CMS is also testing initiatives to speed adoption of best practices, accelerate development and testing of new models, and reform Medicaid and CHIP. These include large collaborations with private stakeholders, including the Million Hearts Program to advance heart health and the Partnership for Patients to improve hospital safety. The Department initiated the Health Care Payment Learning and Action Network to collaborate on aligning reforms across health care sectors.

Through its Medicaid Innovation Accelerator Program, CMS is providing technical support to state Medicaid agencies pursuing delivery system reform related to reducing substance use disorders; improving care for Medicaid beneficiaries with complex care needs and high costs; promoting community integration for beneficiaries using long-term services and supports; and physical and mental health integration.

CMS continues to issue a range of guidance to participants in new models and has begun the regulatory process for the new physician and laboratory payment systems. Additionally, CMS has taken steps to include in new models program integrity safeguards, including transparency of data and monitoring for indicators of abuse or gaming.

## What Needs to Be Done

Much must be accomplished to meet the statutory and Department's reform goals and the promise of better quality of care at lower costs. CMS must manage a broad portfolio of complex models and reforms. CMS must continue to develop clear guidance for providers on program requirements; administer (or contract for) financial, beneficiary alignment, and other systems necessary for effective operations; and test, evaluate, and verify model progress and outcomes. The Department should carefully monitor for successes and benefits that can be scaled and replicated, as well as for potential problems—including inefficiencies and misaligned incentives. Further, CMS must clearly define actionable and meaningful quality measures and ensure that they, in fact, measure what CMS intends them to measure to achieve desired quality goals.

New models rely significantly on data, EHRs, and technology. CMS must ensure that data collected and provided for new payment models is timely, accurate, complete, and secure. Data from providers and others must be integrated and shared across models, as appropriate. (For more information on the challenges associated with electronic information and health IT, see [Management Challenge 3](#).) To the extent that cost and quality performance are measured on the basis of Parts A and B claims data, CMS must ensure the soundness and reliability of such data. (For more information on fraud and abuse in Medicare Parts A and B, see [Management Challenge 2](#)).

CMS must monitor for program integrity risks in new models, incorporate safeguards tailored to specific risks in particular models, and assess the effectiveness of the safeguards it employs. Detected program integrity problems should be remediated promptly and safeguards strengthened to prevent program and patient abuse or gaming. Sharp attention to program integrity is especially important for models that introduce new payment incentives, which might lead to new fraud schemes, or for which waivers of payment or fraud and abuse laws may have been issued under sections 1899(f) or 1115A of the *Social Security Act*. As a critical element of program integrity, CMS must maintain accurate historical and real-time information identifying providers and beneficiaries in new models.

Finally, CMS must strengthen Medicare Advantage to ensure that benefits are provided only to eligible beneficiaries, that data from providers and the plans are available for fraud detection and prevention, and that plans have programs to address fraud and abuse. Ensuring the accuracy of risk-adjustment data used to establish payment rates is also critical to protect against gaming or abuse. CMS must also improve its use of data to review Medicare Advantage organizations' performance.

## Key OIG Resources

- OIG Resources, [Accountable Care Organization Resource Page](#)
- OIG Report, [Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012](#), April 2014
- OIG Report, [Medicare Advantage Organizations' Identification of Potential Fraud and Abuse](#), February 2012
- OIG Report, [CMS Regularly Reviews Part C Reporting Requirements Data, but Its Followup and Use of the Data are Limited](#), March 2014

## Management Challenge 9: Effectively Operating Public Health and Human Services Programs

### Why This Is a Challenge

The Department funds and operates public health and human services programs to promote health and economic and social well-being. These include programs to prevent, track, and treat acute and chronic diseases; respond to natural and man-made disasters; protect against hazardous biological agents; and protect, care for, and educate children. Many of these programs serve vulnerable populations. Effective management is essential to ensure that the programs achieve their goals and best serve the programs' intended beneficiaries.

**Public Health Preparedness and Emergency Response.** Effective protection against public health threats requires a well-coordinated public health infrastructure that can rapidly respond to emergencies at home and internationally. The Department must ensure that health care facilities and personnel are prepared and trained to address emerging infectious diseases and that the proper protocols are in place to foster response coordination with domestic and international partners. Experiences responding to natural disasters, such as Superstorm Sandy, illustrated the important service of first responders and other health care professionals, but also identified gaps in natural disaster emergency planning and execution. Shortcomings related to federal, state, and community organization collaboration; response team communication; shelter operations; and health care coverage were identified. Furthermore, the Department must ensure that select agents (e.g., anthrax, smallpox) remain safe and secure. CDC is tasked with overseeing the handling of select agents in private and government facilities. However, security vulnerabilities identified at many Department research facilities attest to the continuing problems with how these agents are inventoried and handled.

**Access to and Quality of Services.** The Department must ensure that intended beneficiaries of public health and human services have access to services and that these services meet quality standards. Access to quality services has proven especially challenging in IHS, where one hospital recently lost its Medicare provider enrollment after being found to pose immediate jeopardy to patients. Illustrating the challenges of adequately serving another vulnerable population, nearly a third of children in foster care who were enrolled in Medicaid did not receive at least one required health screening, and the Administration for Children and Families (ACF) did not ensure that these children received the required screenings according to state schedules.

**Protecting Vulnerable Populations.** The health and safety of children served by ACF's Child Care and Development Fund (CCDF) program – serving approximately 1.6 million children – continues to be an unaddressed vulnerability for the Department. Vulnerabilities in states' standards for and monitoring of childcare providers jeopardize safety. A total of 454 violations of state licensing requirements were identified, including noncompliance with requirements related to physical conditions, inspection procedures, registration, criminal records or protective service checks, and child abuse and neglect registry checks. In addition, states' onsite monitoring of providers was infrequent, and states did not have enough inspectors to meet the national standard. In 2014, there was an unprecedented, and unpredicted, increase of unaccompanied children arriving in the United States, which required ACF's Office of Refugee Resettlement, in coordination with interagency partners, to implement emergency response measures to quickly expand capacity and provide shelter for a significant number of children. (For general information about challenges associated with grants management and contract administration, see [Management Challenge 4.](#))

## Progress in Addressing the Challenge

The Department is undertaking several initiatives to strengthen federal, state, and community disaster response. The Assistant Secretary for Preparedness and Response (ASPR) launched the Technical Resources Assistance Center and Information Exchange, an emergency preparedness information gateway designed to ensure that all stakeholders have access to information and resources to improve preparedness, response, recovery, and mitigation efforts. With respect to deficiencies in responding to homebound individuals dependent on electrically powered medical equipment, ASPR released the emPOWER map as a tool to help communities plan for the disaster needs of these individuals. CMS is also developing more comprehensive emergency preparedness requirements. In December 2014, CMS published a proposed rule establishing emergency preparedness requirements for Medicare- and Medicaid-participating providers.

The *Consolidated and Further Continuing Appropriations Act, 2015*, provided \$2.7 billion in emergency funding to HHS for Ebola preparedness and response activities. Of this, \$1.77 billion was allocated to CDC to prevent, prepare for, and respond to Ebola domestically and internationally. Through its Hospital Preparedness Program cooperative agreements, ASPR has designated nine health departments and associated partner hospitals to become special regional treatment centers for patients with Ebola or other severe, highly infectious diseases. Through the newly announced National Ebola Training and Education Center, CDC and ASPR will support health care provider and facility training and management of Ebola and other emerging infectious diseases.<sup>33</sup>

The Department has made progress in improving physical security and employee training related to safe and secure storage and handling of select agents. CDC has revised its Vaccines for Children (VFC) Operations Guide, published a *Storage and Handling Toolkit*, and provided additional grantee and provider training to improve vaccine storage and handling practices. CDC also now requires grantees to perform unannounced visits to providers' offices, which was the technique that the OIG used to initially identify VFC program storage and handling vulnerabilities.

The *Child Care and Development Block Grant Act of 2014* (P.L. No. 113-186) reauthorized the CCDF program and improved childcare health, safety, and quality requirements. The law requires states to perform an initial onsite monitoring visit and at least one annual unannounced onsite visit of licensed providers that have received CCDF subsidies, as well as annual inspections for license-exempt CCDF providers. The law also requires childcare providers to submit background checks at least once every 5 years for each childcare staff.

Since the sharp increase of unaccompanied children referred to HHS in the Spring/Summer of 2014, ACF has continued to support and participate in the DHS-led Unified Coordination Group, which monitors all aspects of unaccompanied children arrivals, including HHS and Department of Homeland Security (DHS) programs, along with the collaboration of other federal partners such as the Department of State and the Department of Defense. ACF has also awarded new contracts to support the operations of temporary surge shelters, should they need to be deployed in the future.

## What Needs To Be Done

The Department should continue to promote federal, state, and community collaboration during major disasters. While it may not be possible to predict when and where disasters will strike, the Department should prepare for a range of potential emergency scenarios and be ready to rapidly and effectively respond. Additionally, improvements in the adoption and interoperability of health IT can facilitate medical care for displaced patients by

<sup>33</sup> Lead Inspector General Quarterly Progress Report on US Government Activities, *International Ebola Response and Preparedness*, June 30, 2015

ensuring continuity of access to health records. (For more information on the secure exchange of health information, see [Management Challenge 3](#).)

The Department should move swiftly toward finalizing emergency preparedness regulations. In conjunction with these regulations, detailed and clear guidance should be developed for surveyors assessing compliance with federal regulations. In addition, clear guidance should be developed for the transport of Medicaid patients across state lines. The Department must ensure the sufficiency and training of medical staff for disasters and severe infectious diseases to prepare them to maintain patient care during periods of poor conditions.

The Department will need to continue efforts to improve its inventory control policies and procedures for select agents to resolve vulnerabilities.

ACF should expand the scope of its Child and Family Services Reviews to determine whether children in foster care receive required screenings according to the timeframes specified in states' plans. Furthermore, ACF should work with states to identify the barriers that prevent children in foster care from receiving required screenings and identify, disseminate, and implement strategies for overcoming those barriers. ACF must continue to effectively implement the *Child Care and Development Block Grant Act of 2014* to strengthen the Department's oversight of the health and safety of children. OIG continues to recommend that the Department continue coordination with partner agencies, such as the Department of Homeland Security, to improve its ability to adequately care for unaccompanied children.

### Key OIG Resources

- OIG Reports on emergency preparedness and response, [OEI-06-13-00260](#), [OEI-04-13-00350](#)
- OIG Report, [Division of Unaccompanied Children's Services: Efforts to Serve Children](#), March 2008
- OIG Testimony, [The Foundation for Success: Strengthening the Child Care and Development Block Grant Program](#), March 2014
- OIG Report, [Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings](#), March 2015
- OIG Testimony, [Continuing Concerns with the Federal Select Agent Program: Department Of Defense Shipments of Live Anthrax](#), July 2015

## Management Challenge 10: Ensuring the Safety of Food, Drugs, and Medical Devices

### Why This Is a Challenge

The Department, through FDA, must ensure the safety, efficacy, and security of drugs, biologics, medical devices, dietary supplements, tobacco, feed, and much of our Nation's food supply. However, weaknesses exist. Areas of particularly high risk include drug compounding; the global supply chain; food safety; illegal marketing and promotion; and dietary supplements.

**Compounded Drugs.** Compounded drugs are produced outside of FDA's regulatory process designed to ensure the safety and efficacy of commercially manufactured drugs. The potential danger of compounded drugs drew national attention in 2012, when contaminated compounded sterile drug injections caused a fungal meningitis outbreak. The widespread use of compounded products in health care and FDA's limited ability to effectively oversee compounding entities, which number in the thousands and, generally, do not register with FDA, are causes for concern.

**Imported Food and Drugs.** Foreign sources account for about 40 percent of the drugs, 50 percent of the medical devices, 15 percent of the food, 85 percent of the seafood, and 50 percent of the fresh fruit used by Americans. The global nature and complexity of this supply chain complicates FDA's task of ensuring safety.

**Food Facilities.** Food-borne illnesses, such as those caused by salmonella, listeria and E. coli, pose a continuing public health threat. Despite legal requirements for food facilities to investigate and report adulteration and other serious food-safety concerns, food facilities' failures to comply impede the Department's ability to ensure the safety of the Nation's food supply.

**Off-label Promotion and Kickbacks.** Manufacturers of drugs, biologics, and medical devices gain approval for sale of their products for specific uses once FDA determines that the products are safe and effective for those uses. Once approved for sale, qualified medical providers may prescribe them for any use, including unapproved uses, commonly called "off-label uses." However, manufacturers are prohibited from promoting products for off-label uses. Manufacturers are also prohibited from paying kickbacks to physicians or other health care providers to promote the use of their drug, biologic, or medical device. OIG continues to identify illegal off-label promotion and kickbacks that put patients at risk of receiving inappropriate or harmful care and lead to fraudulent claims for payment from federal health care programs. (For more information on drug diversion and utilization of prescription drugs, see [Management Challenge 5](#)).

**Dietary Supplements.** Dietary supplement manufacturers use structure/function claims to persuade consumers to purchase and use their products. Structure/function claims can describe the effect of a dietary supplement on the structure and function of human bodies but may not claim to prevent, treat, mitigate, cure, or diagnose a disease. Reliable evidence must substantiate these claims as truthful and not misleading, but manufacturers are not required to submit the substantiation to FDA prior to marketing their products, and FDA has only voluntary standards for submission. Those substantiation documents submitted often do not reflect reliable evidence.

### Progress in Addressing the Challenge

In 2013, the *Drug Quality and Security Act* (DQSA), amended the *Federal Food, Drug, and Cosmetic Act* to enhance FDA's authority to oversee compounding, including by providing a new pathway for compounders to register as "outsourcing facilities" to legally compound drugs. The Department continues to work to fully implement DQSA, and FDA has issued numerous policy and guidance documents and increased its inspection and enforcement efforts. FDA continues to inspect compounding facilities; oversee recalls of compounded drugs for contamination or lack of sterility assurance; and issue warning letters to compounders that violate the law.

To address risks associated with imported drugs, FDA has engaged in both outreach and enforcement actions. FDA has undertaken significant efforts to warn consumers, medical practitioners, and others about the risks associated with illegally buying drugs from foreign sources. In addition, FDA has continued to work with OIG and other law enforcement partners to investigate and prosecute physicians and drug suppliers that import unapproved drugs, most notably misbranded, unapproved chemotherapy drugs. Physicians who bill Medicare or Medicaid for such unapproved drugs can be subject to criminal liability under the *False Claims Act* and excluded from participating in federal health care programs. FDA continues to cooperate with international partners and has introduced improved border screening to enhance oversight of imported products.

FDA continues to implement its enhanced food-safety authorities statutorily granted in 2011 by the *Food Safety Modernization Act* (FSMA). In September 2015, FDA promulgated new food safety rules that will require U.S. manufacturers of both human and animal foods to make detailed plans to identify and prevent contamination risks in their production facilities. FDA's food scientists have helped improve genome sequencing technologies to better

detect and prevent foodborne illnesses, and FDA continues to work on improving nutrition and calorie labeling to better inform consumers.

OIG and its law enforcement partners have pursued numerous enforcement actions against drug, biologic, and device manufacturers for illegally promoting their products in ways that could harm patients and waste federal health care program money.

FDA endeavors to continue to make progress in addressing OIG recommendations to improve oversight of dietary supplements. In response to an OIG recommendation, FDA stated that it would consider seeking enhanced authority to review substantiation for structure/function claims.

### What Needs To Be Done

The Department and FDA must continue issuing rules and guidance documents to fully implement FSMA, and DQSA, as well as the July 2012 *Food and Drug Administration Safety and Innovation Act* (FDASIA). FDA must continue to implement its new authorities to enhance oversight of drug compounders and better ensure the safety of compounded products, including by inspecting drug compounders and pursuing regulatory action when deficiencies are identified. OIG plans continued oversight of FDA's inspection of food facilities and monitoring of food recalls. OIG continues to recommend that FDA remedy identified weaknesses in its inspections and recall procedures and better ensure that states properly conduct contracted food facility inspections. The Department also must continue combating off-label promotion and illegal importation of unapproved drugs. OIG, in cooperation with DOJ and other law enforcement partners, will continue to employ investigative and enforcement authorities to protect federal health care programs and beneficiaries from these potentially dangerous products.

### Key OIG Resources

- OIG Report, Penetration Test of the Food and Drug Administration's Computer Network, October 2014
- OIG Report, High-Risk Compounded Sterile Preparations and Outsourcing by Hospitals That Use Them, April 2013
- OIG Report, FDA Lacks Comprehensive Data To Determine Whether Risk Evaluation and Mitigation Strategies Improve Drug Safety, February 2013
- OIG Report, Dietary Supplements: Structure/Function Claims Fail to Meet Federal Requirements, October 2012



## DEPARTMENT'S RESPONSE TO THE OFFICE OF INSPECTOR GENERAL TOP MANAGEMENT CHALLENGES



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: Mary K. Wakefield, Acting Deputy Secretary

Subject: FY 2015 Top Management and Performance Challenges Identified by the Office of Inspector General

Thank you for the Office of Inspector General's work in assessing the major management and performance challenges facing the Department as we begin the new fiscal year. We appreciate OIG's audit and investigative work throughout the year.

The suggestions you offer to address these challenges will help us drive progress on our Agency Priority Goals. The Department's Operating Divisions continue to focus on serving all Americans by protecting their health, providing essential human services, and promoting the well-being of individuals, families and communities. OIG's work will help us do this in the most effective and efficient way possible.

We are committed to focusing our resources on the issues related to these challenges as we work toward implementing our strategic plan in FY 2016.

/Mary K. Wakefield/

Mary K. Wakefield  
Acting Deputy Secretary  
November 13, 2015

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# Appendices



*About the photo*

*Secretary Burwell with Public Health Service Officers at the 2015 HHS “Night at the Ballpark” (Washington Nationals Stadium).*

## In This Section

- Acronyms
- Connect with HHS

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## APPENDIX A: ACRONYMS

AA	Associate of Arts
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACO	Accountable Care Organization
ADA	<i>Anti-Deficiency Act</i>
AFR	Agency Financial Report
AGA	Association of Government Accountants
AHRQ	Agency for Healthcare Research and Quality
AICPA	American Institute of Certified Public Accountants
ALJ	Administrative Law Judge
AOA	Administration on Aging
APG	Agency Priority Goal
APMs	Alternative Payment Models
APPs	Applications
APTC	Advance premium tax credits
ASA	Office of the Assistant Secretary for Administration
ASC	Ambulatory Surgical Center
ASFR	Office of the Assistant Secretary for Financial Resources
ASL	Office of the Assistant Secretary for Legislation
ASPA	Office of the Assistant Secretary for Public Affairs
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
ATM	Accounting Treatment Manual
ATSDR	Agency for Toxic Substances and Disease Registry
BA	Bachelor of Arts
BARDA	Biomedical Advanced Research and Development Authority
BHP	Basic Health Plan
BRAIN	Brain Research through Advancing Innovative Neurotechnologies
CAHs	Critical Access Hospitals
CAIVRS	Urban Development's Credit Alert Interactive Voice Response System
CAP(s)	Corrective Action Plan(s)
CAUTI	Catheter-Associated Urinary Tract Infections
CBRs	Comparative Billing Reports
CCDBG	<i>Child Care and Development Block Grant Act of 2014</i>
CCDF	Child Care Development Fund
CCIO	Center for Consumer Information and Insurance Oversight
CDC	Centers for Disease Control and Prevention
CDER	Common Data Element Repository
CEAR	<i>Certificate of Excellence in Accountability Reporting</i>
CERT	Comprehensive Error Rate Testing
CFBNP	Center for Faith-Based and Neighborhood Partnerships
CFO	Chief Financial Officer
<i>CFO Act</i>	<i>Chief Financial Officers Act of 1990</i>
CFR	Code of Federal Regulations
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CHIPRA	<i>Children's Health Insurance Program Reauthorization Act of 2009</i>
CIO	Chief Information Officer
CL	Current Law
CMA	Computer Matching Agreement
CMMI	Center for Medicare and Medicaid Innovation
CMP	Civil Monetary Penalties
CMS	Centers for Medicare and Medicaid Services
CO-OP	Consumer Operated and Oriented Plan
COLA	Cost of Living Adjustment
COTS	Commercial Off the Shelf
CPI	Consumer Price Index
CPI-W	Consumer Price Index for Urban Wage Earners and Clerical Workers
CPIC	Certification Package for Internal Controls
CPIM	Consumer Price Index-Medical
CRC	Commercial Repayment Center

CSR	Cost-sharing reductions
CSRS	Civil Service Retirement System
CUSP	Comprehensive Unit-Based Safety Program
CY	Current Year
DAB	Departmental Appeals Board
<i>DATA Act</i>	<i>Digital Accountability and Transparency Act of 2014</i>
DEA	Drug Enforcement Agency
DHS	Department of Homeland Security
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment Prosthetics Orthotics and Supplies
DMF	Death Master File
DNP	Do Not Pay
DOD	Department of Defense
DOI	Department of the Interior
DOJ	Department of Justice
DOL	Department of Labor
DQSA	<i>Drug Quality and Security Act</i>
DRA	<i>Deficit Reduction Act of 2005</i>
DSWG	Data Standardization Working Group
EHR	Electronic Health Records
EO	Executive Order
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERM	Enterprise Risk Management
ES	Executive Secretariat
ESRD	End-Stage Renal Disease
FAQ	Frequently Asked Questions
FASAB	Federal Accounting Standards Advisory Board
FBIP	Financial Business Intelligence Program
FBIS	Financial Business Intelligence System
FBWT	Fund Balance with Treasury
FDA	Food and Drug Administration
FDASIA	<i>Food and Drug Administration Safety and Innovation Act</i>
FECA	<i>Federal Employees' Compensation Act</i>
FERS	Federal Employees' Retirement System
FETP	Field Epidemiology Training Program
FFM	Federally Facilitated Marketplace
FFMIA	<i>Federal Financial Management Improvement Act of 1996</i>
FFRDC	Federally Funded Research and Development Center
FFR	Federal Financial Report
FFS	Fee-for-Service
FGB	Financial Management Governance Board
FICA	<i>Federal Insurance Contributions Act</i>
FIFO	First-in/first-out
FISCAM	Federal Information Systems Control Audit Manual
FISMA	<i>Federal Information Security Management Act of 2002</i>
FITARA	<i>Federal Information Technology Acquisition Reform Act</i>
FMAP	Federal Medical Assistance Percentage
FMFIA	<i>Federal Managers' Financial Integrity Act of 1982</i>
FPL	Federal Poverty Level
FPS	Fraud Prevention System
FR	Final Rule
FSIP	Financial Systems Improvement Program
FSMA	<i>Food Safety Modernization Act</i>
FVPS	Family Violence Prevention and Services
FWA	Fraud, waste, and abuse
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	Government Accountability Office
GDP	Gross Domestic Product
GHP	Group Health Plan
GMRA	<i>Government Management Reform Act of 1994</i>
GPRA	<i>Government Performance and Results Act of 1993</i>
GSA	General Services Administration

<b>HAIs</b>	Healthcare-Associated Infections
<b>HCBS</b>	Home-and community-based- services
<b>HEW</b>	Health, Education, and Welfare
<b>HFPP</b>	Healthcare Fraud Prevention Partnership
<b>HHAs</b>	Home Health Agencies
<b>HHS</b>	Department of Health and Human Services
<b>HI</b>	Hospital Insurance
<b>HIGLAS</b>	Healthcare Integrated General Ledger Accounting System
<b>HIPAA</b>	<i>Health Insurance Portability and Accountability Act of 1996</i>
<b>HIV</b>	Human Immunodeficiency Virus
<b>HRSA</b>	Health Resources and Services Administration
<b>HSOPS</b>	Hospital Survey of Patient Safety
<b>HSN1</b>	Avian Influenza
<b>IBNR</b>	Incurred But Not Reported
<b>ICD-10</b>	International Classification of Diseases, 10th Revision
<b>ICOFR</b>	Internal Controls over Financial Reporting
<b>ICUs</b>	Intensive Care Units
<b>IEA</b>	Office of Intergovernmental and External Affairs
<b>IEVS</b>	Income Eligibility Verification System
<b>IHS</b>	Indian Health Service
<b>IOS</b>	Immediate Office of the Secretary
<b>IP</b>	Improper Payments
<b>IPAB</b>	Independent Payment Advisory Board
<b>IPERA</b>	<i>Improper Payments Elimination and Recovery Act of 2010</i>
<b>IPERIA</b>	<i>Improper Payments Elimination and Recovery Improvement Act of 2013</i>
<b>IPIA</b>	<i>Improper Payments Information Act of 2002</i>
<b>IRS</b>	Internal Revenue Service
<b>IT</b>	Information Technology
<b>LEIE</b>	List of Excluded Individuals & Entities
<b>LLP</b>	Limited Liability Partnership
<b>MA</b>	Medicare Advantage or Part C
<b>MACRA</b>	<i>Medicare Access and CHIP Reauthorization Act</i>
<b>MACs</b>	Medicare Administrative Contractors
<b>MAO</b>	Medicare Advantage Organizations
<b>MARx</b>	Medicare Advantage Prescription Drug
<b>MD&amp;A</b>	Management's Discussion and Analysis
<b>MEDIC</b>	Medicare Drug Integrity Contractors
<b>MFCUs</b>	Medicaid Fraud Control Units
<b>MICs</b>	Medicaid Integrity Contractors
<b>MIDAS</b>	Multidimensional Insurance Data Analytics System
<b>MII</b>	Medicaid Integrity Institute
<b>MLN</b>	Medicare Learning Network
<b>MMA</b>	<i>Medicare Prescription Drug, Improvement and Modernization Act of 2003</i>
<b>MMIS</b>	Medicaid Management Information Systems
<b>MMWR</b>	Morbidity and Mortality Weekly Report
<b>MOE</b>	Maintenance of Effort
<b>MSIS</b>	Medicaid Statistical Information Systems
<b>MSP</b>	Medicare Secondary Payer
<b>MWWG</b>	Material Weakness Working Group
<b>NBI</b>	National Benefit Integrity
<b>NBS</b>	NIH Business Systems
<b>NCCI</b>	National Correct Coding Initiative
<b>NDNH</b>	National Directory of New Hires
<b>NGHP</b>	Non-Group Health Plan
<b>NHSC</b>	National Health Service Corps
<b>NHSN</b>	National Healthcare Safety Network
<b>NIH</b>	National Institutes of Health
<b>NIP</b>	National Provider Identifier
<b>NJDCF</b>	New Jersey Department of Children and Families
<b>NPRM</b>	Notice of Proposed Rulemaking
<b>NYSOCFS</b>	New York State Office of Children and Family Services
<b>OACT</b>	Office of the Actuary
<b>OASDI</b>	Old-Age Survivors and Disability Insurance
<b>OASH</b>	Office of the Assistant Secretary for Health
<b>OCR</b>	Office for Civil Rights
<b>OGA</b>	Office of Global Affairs

<b>OGC</b>	Office of the General Counsel
<b>OHR</b>	Office of Health Reform
<b>OIG</b>	Office of Inspector General
<b>OMB</b>	Office of Management and Budget
<b>OMH</b>	Office of Minority Health
<b>OMHA</b>	Office of Medicare Hearings and Appeals
<b>ONC</b>	Office of the National Coordinator for Health Information Technology
<b>OPD</b>	Orphan Products Development
<b>OpDiv</b>	Operating Division
<b>OS</b>	Office of the Secretary
<b>PARIS</b>	Public Assistance Reporting Information System
<b>PCS</b>	Personal Care Services
<b>PDE</b>	Prescription Drug Event
<b>PEDIR</b>	Payment Error related to Direct and Indirect Remuneration
<b>PELS</b>	Payment Error related to Low-Income Subsidy Status
<b>PEMS</b>	Payment Error related to Medicaid Status
<b>PEPPER</b>	Program for Evaluating Payment Patterns Electronic Report
<b>PEPV</b>	Prescription Drug Event Data Validation
<b>PERM</b>	Payment Error Rate Measurement
<b>PFCRA</b>	<i>Program Fraud Civil Remedies Act</i>
<b>PHD</b>	Doctor of Philosophy
<b>PHS</b>	Public Health Service
<b>PIP</b>	Program Improvement Plan
<b>PMDs</b>	Power Mobility Devices
<b>PMO</b>	Program Management Office
<b>PMS</b>	Payment Management System
<b>PP&amp;E</b>	Property, Plant and Equipment
<b>PPS</b>	Prospective Payment System
<b>PPV</b>	Plan Payment Validation
<b>PRRB</b>	Provider Reimbursement Review Board
<b>PSC</b>	Program Support Center
<b>PTC</b>	Premium Tax Credit
<b>PUPS</b>	Prisoner Update Processing System
<b>PUR</b>	Period Under Review
<b>PY</b>	Prior Year
<b>QAPI</b>	Quality Assurance and Performance Improvement
<b>QHP</b>	Qualified Health Plans
<b>QIO</b>	Quality Improvement Organization
<b>QM</b>	Quality Measures
<b>QRIS</b>	Quality Rating and Improvement Systems
<b>QRP</b>	Quality Reporting Program
<b>RAC</b>	Recovery Audit Contractor
<b>RADV</b>	Risk Adjustment Data Validation
<b>RMFOB</b>	Risk Management and Financial Oversight Board
<b>RSI</b>	Required Supplementary Information
<b>RSSI</b>	Required Supplementary Stewardship Information
<b>SACWIS</b>	Statewide Automated Child Welfare Information System
<b>SAM</b>	General Service Administration's System for Award Management
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SBIR</b>	Small Business Innovation Research
<b>SBJA</b>	<i>Small Business Jobs Act of 2010</i>
<b>SE</b>	Salmonella Enteritidis
<b>SECA</b>	<i>Self Employment Contribution Act of 1954</i>
<b>SF</b>	Standard Form
<b>SFFAS</b>	Statement of Federal Financial Accounting Standards
<b>SGR</b>	Sustainable Growth Rate
<b>SHRAP</b>	Sandy Homeowner and Renter Assistance Program
<b>SIR</b>	Standard Infection Ratio
<b>SMI</b>	Supplementary Medical Insurance
<b>SMRC</b>	Supplemental Medical Review/Specialty Contractor
<b>SNAP</b>	Supplemental Nutrition Assistance Program
<b>SNF</b>	Skilled Nursing Facility
<b>SNS</b>	Strategic National Stockpile
<b>SPA</b>	State Plan Amendments
<b>SSA</b>	Social Security Administration
<b>SSAE</b>	Statement on Standards for Attestation Engagements

<b>SSBG</b>	Social Services Block Grant
<b>SSF</b>	Service and Supply Fund
<b>StaffDiv</b>	Staff Division
<b>STEM</b>	Science, Technology, Engineering and Mathematics
<b>STTR</b>	Small Business Technology Transfer
<b>TANF</b>	Temporary Assistance for Needy Families
<b>TBI</b>	Traumatic Brain Injury
<b>TIN</b>	Taxpayer Identification Number
<b>T-MSIS</b>	Transformed Medical Shared Information Saving Program
<b>TNC</b>	Treasury Nominal Coupon
<b>TOP</b>	Treasury's Offset Program
<b>TREASURY</b>	Department of the Treasury
<b>UFMS</b>	Unified Financial Management System
<b>U.S.</b>	United States
<b>U.S.C.</b>	U.S. Code
<b>USDA</b>	U.S. Department of Agriculture
<b>USSGL</b>	U.S. Standard General Ledger
<b>VA</b>	Department of Veterans Affairs
<b>VBP</b>	Value-Based Purchasing
<b>VFC</b>	Vaccines for Children
<b>WIOA</b>	<i>Workforce Innovation and Opportunity Act</i>

## APPENDIX B: CONNECT WITH HHS



*The Hubert H. Humphrey Building, headquarters of the U.S. Department of Health and Human Services, was the first federal building dedicated to a living person.*

Thank you for your interest in HHS's FY 2015 AFR. We welcome your comments on how we can make this report more informative for our readers. Please send your comments to:

Mail: U.S. Department of Health and Human Services  
Office of Finance/Office of Financial Reporting and Policy  
Mail Stop 549D  
200 Independence Avenue, S.W.  
Washington, DC 20201

Email: [HHSAFR@hhs.gov](mailto:HHSAFR@hhs.gov)

Electronic copies of this report and prior years' reports are available through the Department's website: [www.hhs.gov/AFR](http://www.hhs.gov/AFR)

You can also stay connected with HHS via the social media sites listed below:



**Facebook:** [www.facebook.com/HHS](http://www.facebook.com/HHS)

**Twitter:** [www.twitter.com/hhsgov](http://www.twitter.com/hhsgov)

**YouTube:** [www.youtube.com/user/USGOVHHS](http://www.youtube.com/user/USGOVHHS)

**Flickr:** [www.flickr.com/photos/hhsgov](http://www.flickr.com/photos/hhsgov)

**Pinterest:** [www.pinterest.com/hhsgov](http://www.pinterest.com/hhsgov)

**GooglePlus:** [www.plus.google.com/+HHS/posts](http://www.plus.google.com/+HHS/posts)



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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

200 Independence Ave, S.W. • Washington, DC 20201

877.696.6775 • [www.hhs.gov](http://www.hhs.gov)



November 16, 2015

The Honorable Tom Price  
Chairman  
Committee on Budget  
United States House of Representatives  
100 Cannon House Office Building  
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the *Reports Consolidation Act*, I am pleased to submit the Fiscal Year 2015 Agency Financial Report (AFR) for the Department of Health and Human Services (HHS). The AFR is located on our website at <http://www.hhs.gov/afr/>.

I am proud to report that HHS obtained an unmodified or "clean" opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Patient Protection and Affordable Care Act* and the impact of potential changes in law that would influence underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2015 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board.

The Centers for Medicare & Medicaid Services (CMS), an Operating Division of HHS, published an audited annual financial report under separate cover. This report will go out for distribution on Monday, November 16, 2015 and will be available on CMS's website at <http://www.cms.hhs.gov/CFORReport/>.

Thank you for your continued interest in the Department's stewardship of taxpayer funds. If you have any questions, please contact me at (202) 690-6396.

Sincerely,

A handwritten signature in black ink, reading "Ellen G. Murray".

Ellen G. Murray  
Assistant Secretary for Financial Resources  
and Chief Financial Officer

**From:** [Schlichting, Emily \(HHS/ASL\)](#)  
**To:** [Jim.Herz@mail.house.gov](mailto:Jim.Herz@mail.house.gov)  
**Subject:** FY16 Agency Financial Report  
**Date:** Tuesday, November 15, 2016 5:25:00 PM  
**Attachments:** [Tom Price - AFR Letter.pdf](#)  
[fy-2016-hhs-agency-financial-report.pdf](#)

---

Hello,

Attached please find a letter notifying your boss of the FY16 Agency Financial Report for HHS and the full report.

Thanks,  
Emily

**Emily Schlichting**

Chief of Staff  
Office of the Assistant Secretary for Legislation  
U.S. Department of Health and Human Services  
202-690-7414 | [emily.schlichting@hhs.gov](mailto:emily.schlichting@hhs.gov)



November 15, 2016

The Honorable Tom Price  
Chairman  
Committee on Budget  
United States House of Representatives  
100 Cannon House Office Building  
Washington, D.C. 20515

Dear Mr. Chairman:

I am delighted to submit the Fiscal Year 2016 Agency Financial Report (AFR) for the Department of Health and Human Services (HHS). In accordance with the *Reports Consolidation Act*, HHS is committed to delivering a quality AFR that displays summary performance results, accomplishments, and finances for the fiscal year. As you read HHS's AFR, you will see that the report provides the President, Congress, and the American people a comprehensive look into HHS's financial condition, as well as insight into how HHS carries out its mission and makes a difference for the American people. The AFR is located on our website at <http://www.hhs.gov/afr/>.

HHS obtained an unmodified or "clean" opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Patient Protection and Affordable Care Act* and the impact of potential changes in law that would influence underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2016 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board.

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Thank you for your continued interest in the Department's stewardship of taxpayer funds. If you have any questions, please contact me at (202) 690-6396.

Sincerely,

A handwritten signature in black ink, appearing to read "Ellen G. Murray", is written over the word "Sincerely,".

Ellen G. Murray  
Assistant Secretary for Financial Resources  
and Chief Financial Officer

# Department of Health and Human Services



*Advancing the health, safety, and well-being of the nation*

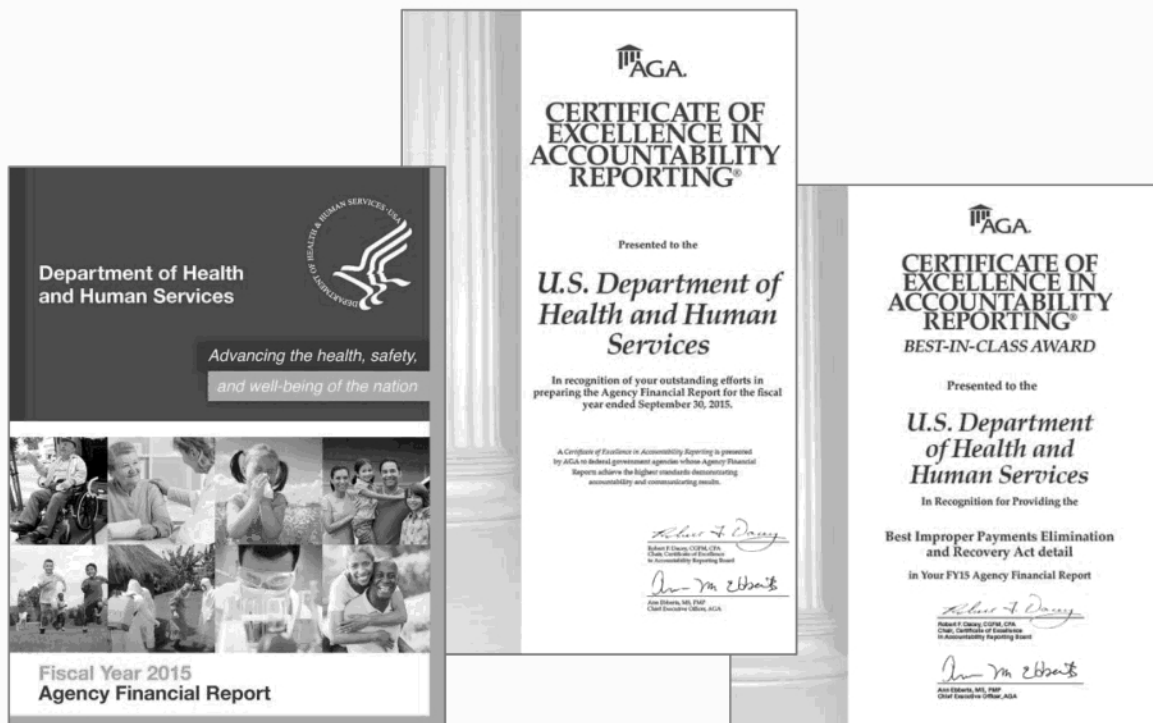


**FY 2016**  
**Agency Financial Report**

# Certificate of Excellence in Accountability Reporting

In May 2016, the U.S. Department of Health and Human Services (HHS) received the Certificate of Excellence in Accountability Reporting (CEAR) from the Association of Government Accountants (AGA) for its Fiscal Year (FY) 2015 Agency Financial Report. The CEAR Program was established by the AGA in collaboration with the Chief Financial Officers Council and the U.S. Office of Management and Budget to further performance and accountability reporting. Through the program, agencies improve accountability by streamlining reporting and improving the effectiveness of such reports to clearly show what an agency accomplished with taxpayer dollars and the challenges that remain. FY 2015 marked the third consecutive year the Department received this prestigious award.

AGA also presented HHS with a Best in Class Award for the Best Improper Payments Elimination and Recovery Act Detail.



Note: This document is currently undergoing Section 508 remediation. Should you need assistance, please contact the HHS AFR Team at [HHSAFR@hhs.gov](mailto:HHSAFR@hhs.gov).



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## MESSAGE FROM THE SECRETARY



Sylvia M. Burwell

Our mission at the U.S. Department of Health and Human Services (HHS) is to enhance and protect the health and well-being of all Americans. We fulfill that mission by providing effective services and fostering advances in medicine, public health, and social services. We are committed to ensuring that every American has access to the building blocks for healthy and productive lives.

I am pleased to present HHS's Fiscal Year 2016 Agency Financial Report. This report highlights our major accomplishments, illustrates how we manage our resources, and outlines our plans to address the challenges we face. At HHS, we are dedicated to meeting high standards of government reporting and accountability.

HHS administers more than 300 programs that enhance the well-being of others. The HHS FY 2014-2018 Strategic Plan helps guide the Department's programs within

the context of four strategic goals:

- Strengthen health care
- Advance scientific knowledge and innovation
- Advance the health, safety and well-being of the American people
- Ensure efficiency, transparency, accountability and effectiveness of HHS programs

Together, these goals form our vision for how HHS can contribute to a stronger, healthier, and more prosperous America, both today and for many years to come.

**FY 2016 Significant Activities**

The provisions of the *Affordable Care Act*, and our efforts to strengthen our health care system, have helped an estimated 20 million people gain health coverage since the passage of the law in 2010, a historic reduction in the uninsured. We are committed to reaching even more Americans during the fourth open enrollment of the Health Insurance Marketplace and making it easier for them to access affordable, quality health coverage. Today, no American can be denied health coverage because of a pre-existing condition, young adults can stay on a parent's plan until they turn 26, and we have strengthened the quality of coverage.

We are also committed to advancing the health, safety, and well-being of the American people by detecting global health threats early, responding quickly, working with partners across the globe, and building the capacity necessary to deal with these threats. This commitment, and our network of global partners, helped to resolve the Ebola crisis, and it is guiding our efforts to fight the Zika virus today.

More than 50 countries and territories have active Zika virus transmission, and in February 2016, the World Health Organization declared that the clusters of microcephaly and other neurological complications associated with the Zika virus constituted a Public Health Emergency of International Concern. Tens of thousands of Zika cases have been reported in the United States and its territories, including thousands of pregnant women who are at particular risk because of the severe birth defects that Zika infection can cause. HHS is working with states and territories to improve mosquito control and increase laboratory capacity, and working with private sector partners to accelerate the development of diagnostic tests as well as a Zika vaccine. Researchers at the National Institutes of Health have been working tirelessly to develop a safe and effective Zika vaccine, and thanks to their work, NIH recently began human trials of a vaccine candidate – an important milestone they reached nearly a decade faster than with typical vaccines. It will take some time before a vaccine is commercially available, but the launch of this study is an important step forward.

To better serve the American people, we need to constantly search for new ideas and innovative ways to improve

how we do business. That is where the HHS Innovation, Design, Entrepreneurship and Action (IDEA) Lab comes in. The IDEA Lab promotes the use of innovation across HHS, taking advantage of the talent of the workforce at HHS and removing the barriers that stand in their way. One of the greatest impacts we have seen has come from the Health Data Initiative, which aims to improve health and the delivery of human services by harnessing the power of data in public and private sector institutions, communities, and research groups. The initiative has liberated more than 2,100 health data sets, helping to power the growth of the health care start-up ecosystem. Unlocking health care data and information is part of the Department's strategy to build a health care delivery system that is better, smarter, and healthier and ultimately puts patients in the center of their care.

### **Financial Management**

As responsible stewards of the resources the American taxpayers and Congress entrust to us, one of our most important duties is to practice fiscal responsibility and transparency. To that end, our independent Department-wide financial statement audit is one of our most important tools. This year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2016 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. The "Financial Section" of this report includes more detailed information.

As required by the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) and the Office of Management and Budget's Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, we also evaluated our internal controls and financial management systems. We identified one material weakness relating to Information System Controls and Security. We also identified two material noncompliances relating to Error Rate Measurement and the Medicare appeals process. Our senior leadership continues efforts to improve our financial reports and systems. The "Management's Discussion and Analysis" section of this report includes further details. Based on our internal assessments and the auditors' report, I believe that our financial and performance data are reliable and complete.

### **Management Opportunities and Challenges**

Despite our successes, HHS still faces opportunities for improvement. We have worked closely with the Office of Inspector General to gain its perspective about our most significant management and performance challenges, which are presented in the "Other Information" section under *FY 2016 Top Management and Performance Challenges Identified by the Office of Inspector General*. The HHS Inspector General identified 10 performance challenges that present opportunities for improvement. These challenges, which we are committed to overcoming, include delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity.

### **Conclusion**

As it has for many decades now, our Department will continue to protect the health and well-being of the American people, and of people around the globe. I have no doubt that well after this Administration concludes, the dedicated public servants here at HHS will continue to strengthen existing relationships and forge new ones with people and organizations committed to helping Americans access the building blocks for healthy and productive lives. I look forward to seeing the impact that HHS will deliver for many decades to come.

/Sylvia M. Burwell/

Sylvia M. Burwell  
Secretary  
November 14, 2016

## ABOUT THE AGENCY FINANCIAL REPORT

The HHS FY 2016 AFR provides fiscal and summary performance results that enable the President, Congress, and the American people to assess our accomplishments for the reporting period October 1, 2015, through September 30, 2016. This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We prepared this report in accordance with the requirements of the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements*. This document consists of three primary sections and appendices:



### Section 1: Management's Discussion and Analysis

The Management's Discussion and Analysis section provides an overview of the Department's performance and financial information. It introduces its mission, and describes the Department's organizational structure. This section highlights HHS's goals and priorities and summarizes the results for select key performance measures. It also highlights the Department's financial results and provides management's assurances on HHS's internal controls.



### Section 2: Financial Section

The Financial Section begins with a message from the Chief Financial Officer. It details the Department's finances and includes the audit transmittal letter from the Inspector General, the independent auditors' report, and the principal financial statements and notes. The required supplementary information included in this section provides the Combining Statement of Budgetary Resources, and Deferred Maintenance and Repairs, and Social Insurance information.



### Section 3: Other Information

The Other Information section begins with the Combined Schedule of Spending, Freeze the Footprint baseline square footage cost and data, and Civil Monetary Penalty Adjustment for Inflation information. It also includes the Improper Payments Information Act Report, a summary of the results of the Department's financial statement audit and management assurances, and the Inspector General's assessment of the Department's management and performance challenges.




### Appendices

The appendices include data that support the main sections of the AFR. This includes a glossary of acronyms used in the report and resources for connecting with the Department.

The Department has chosen to produce an AFR and *Annual Performance Plan and Report*. In February 2017, additional reports that will be available on HHS/About HHS/Budget & Performance ([www.hhs.gov/about/budget](http://www.hhs.gov/about/budget)) include:

1. FY 2018 *Annual Performance Plan and Report*
2. FY 2018 *Congressional Budget Justification*

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# Management's Discussion and Analysis

# 1

## In This Section

- About the Department of Health and Human Services
- Performance Goals, Objectives, and Results
- Systems, Legal Compliance, and Internal Control
- Management Assurances
- Looking Ahead to 2017
- Financial Summary and Highlights

## Did you know?

This year marks the Centers for Disease Control and Prevention's (CDC) 70th Anniversary. For 70 years, CDC has put proven science into action to keep Americans safe from health threats. Its forerunner, the Communicable Disease Center was established on July 1, 1946, focusing on the fight against malaria. Today, CDC is the nation's premier promotion, disease prevention and emergency preparedness agency and a global leader in public health.

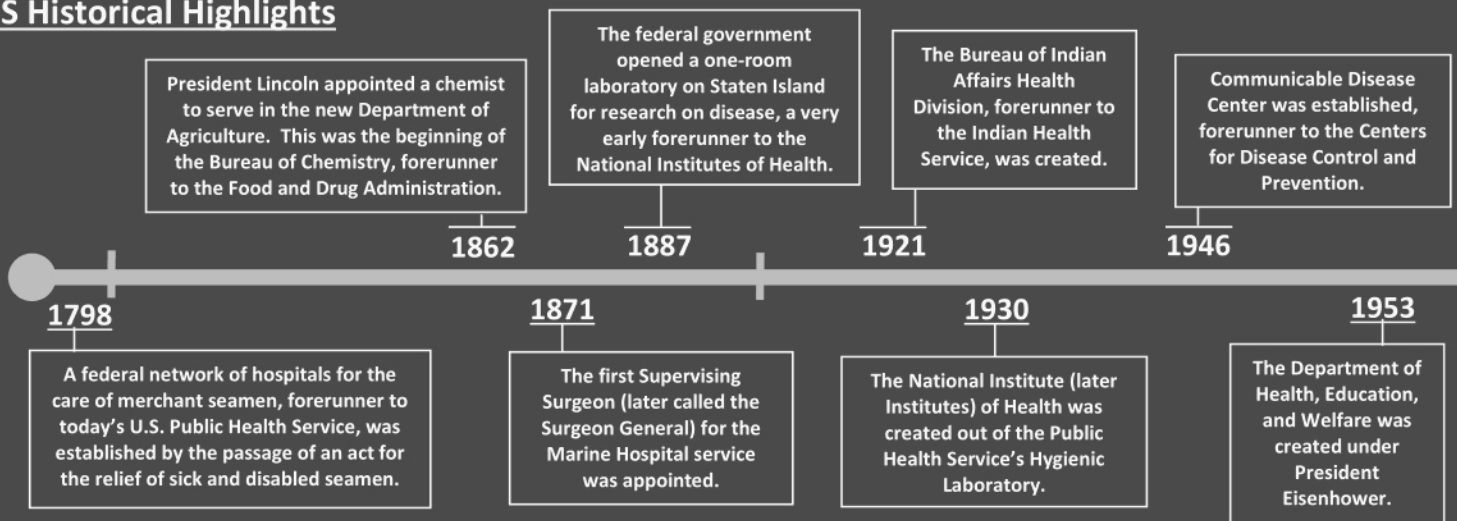


CDC, circa 1946



CDC Today

## HHS Historical Highlights



## ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Mission Statement

The mission of the United States (U.S.) Department of Health and Human Services (HHS) is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences, underlying medicine, public health, and social services.

### Vision Statement

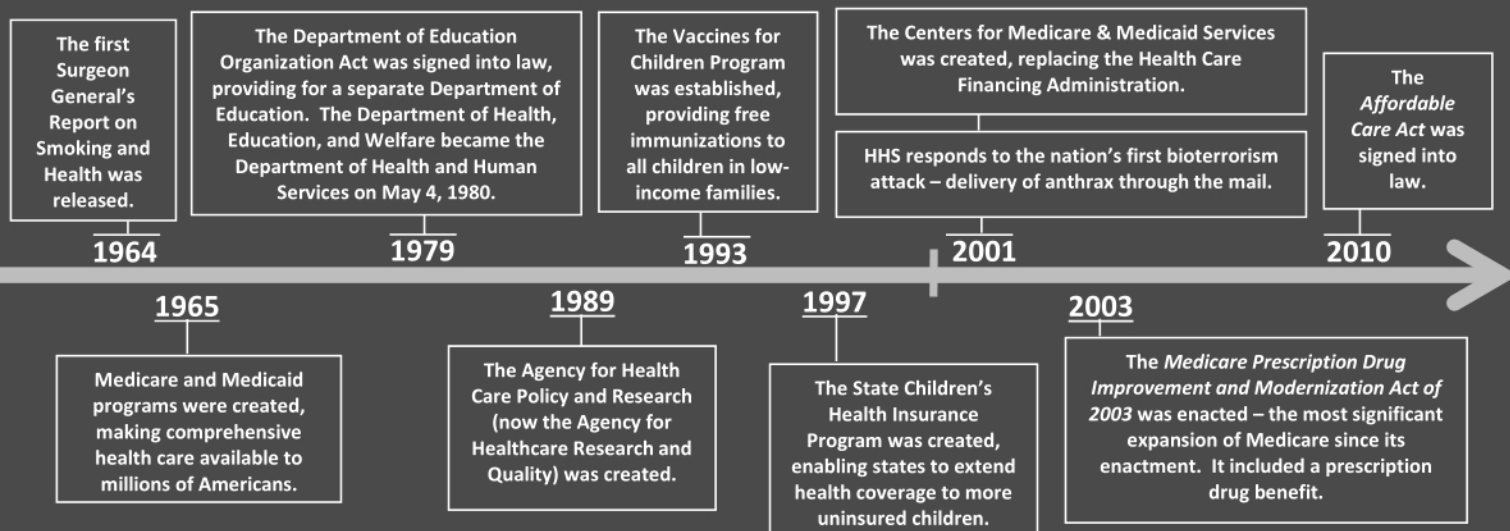
The vision of HHS is to provide the building blocks that Americans need to live healthy, successful lives.

### Purpose

HHS is the U.S. government's principal agency for protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. HHS is responsible for almost a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than one billion claims per year. Medicare and Medicaid together provide health care insurance for 1 in 3 Americans.

HHS works closely with state and local governments, and many HHS-funded services are provided at the local level by state or county agencies, or through private sector grantees. The HHS Office of the Secretary and its 11 Operating Divisions (OpDivs) administer more than 300 programs covering a wide spectrum of activities. In addition to the services they deliver, HHS programs provide for equitable treatment of beneficiaries nationwide and enable the collection of national health and other data. HHS, through its programs and partnerships:

- Provides health care coverage to more than 100 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace;
- Promotes patient safety and health care quality in health care settings and by health care providers, by assuring the safety, effectiveness, quality, and security of foods, drugs, vaccines, and medical devices;





## ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Eliminates disparities in health, as well as health care access and quality, and protects vulnerable individuals and communities from poor health and human services outcomes;
- Conducts health and social science research with the largest source of funding for medical research in the world, while creating hundreds of thousands of high-quality jobs for scientists in universities and research institutions in every state across America and around the globe;
- Leverages health information technology to improve the quality of care and to use HHS data to drive innovative solutions to health, public health, and human services challenges;
- Improves maternal and infant health; promotes the safety, well-being, and healthy development of children and youth; and supports young people's successful transition to adulthood;
- Promotes economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities;
- Supports wellness efforts across the life span, from protecting mental health, to preventing risky behaviors such as tobacco use and substance abuse, to promoting better nutrition and physical activity;
- Prevents and manages the impacts of infectious diseases and chronic diseases and conditions, including the top causes of disease, disability, and death;
- Prepares Americans for, protects Americans from, and provides comprehensive responses to health, safety, and security threats, both foreign and domestic, whether natural or man-made; and
- Serves as responsible stewards of the public's investments.

### Organizational Structure

HHS's organizational structure is designed to accomplish its mission and provide a framework for sound business operations and management controls. The Office of the Secretary, with the Secretary, provides the overarching vision and strategic direction for the Department, and leads HHS and its 11 OpDivs to provide a wide range of services and benefits to the American people. Each OpDiv contributes to our mission and vision as follows:



**Administration for Children and Families (ACF)** is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF programs aim to empower families and individuals to increase their economic independence and productivity, and encourage strong, healthy, supportive communities that have a positive impact on quality of life and the development of children. For more information, visit [www.acf.hhs.gov](http://www.acf.hhs.gov).



**Administration for Community Living (ACL)** was created around the fundamental principle that all people, regardless of age or disability, should be able to live where they choose, with the people they choose, and fully participate in their communities. By advocating for older adults and people with disabilities, and the families and caregivers of both across the federal government; funding services and supports provided by networks of community-based organizations; and investments in research and innovation, ACL helps make this principle a reality for millions of Americans. For more information, visit [www.acl.gov](http://www.acl.gov).

## ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES



**Agency for Healthcare Research and Quality (AHRQ)** produces evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within HHS and with other partners to make sure that the evidence is understood and used. This mission is supported by focusing on (1) improving health care quality, (2) making health care safer, (3) increasing accessibility, and (4) improving health care affordability, efficiency, and cost transparency. For more information, visit [www.ahrq.gov](http://www.ahrq.gov).



**Agency for Toxic Substances and Disease Registry (ATSDR)** is charged with the prevention of exposure to toxic substances and the prevention of the adverse health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment. For more information, visit [www.atsdr.cdc.gov](http://www.atsdr.cdc.gov).



**Centers for Disease Control and Prevention (CDC)** collaborates to create the expertise, information, and tools that people and communities need to protect their health through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. CDC works to protect America from health, safety, and security threats, both foreign and domestic. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights diseases and supports communities and citizens to do the same. For more information, visit [www.cdc.gov](http://www.cdc.gov).



**Centers for Medicare & Medicaid Services (CMS)** administers public insurance programs that serve as the primary sources of health care coverage for seniors and a large population of medically vulnerable individuals. CMS acts as a catalyst for enormous changes in the availability and quality of health care for all Americans. In addition to these programs, CMS has the responsibility to ensure effective, up-to-date health care coverage, and to promote quality care for beneficiaries. CMS is also responsible for helping to implement many provisions of the *Patient Protection and Affordable Care Act (Affordable Care Act)*, such as the establishment of the Federally Facilitated Marketplace. For more information, visit [www.cms.gov](http://www.cms.gov).



**Food and Drug Administration (FDA)** is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation.

FDA is also responsible for advancing the public health by helping to speed innovations that make medicines more effective, safer, and more affordable and by helping the public get the accurate, science-based information it needs to use medicines and foods to maintain and improve their health. FDA also has responsibility for regulating the manufacturing, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors.

Finally, FDA plays a significant role in the nation's counterterrorism capability. FDA fulfills this responsibility by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats. For more information, visit [www.fda.gov](http://www.fda.gov).



**Health Resources and Services Administration (HRSA)** is responsible for improving access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. HRSA's programs provide health care to people who are geographically isolated, and economically, or medically vulnerable. For more information, visit [www.hrsa.gov](http://www.hrsa.gov).



**Indian Health Service (IHS)** is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. IHS is the principal federal health care provider and health advocate for the Indian people, with the goal of raising Indian health status to the highest possible level. IHS provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 36 states. For more information, visit [www.ihs.gov](http://www.ihs.gov).



**National Institutes of Health (NIH)** seeks fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. For more information, visit [www.nih.gov](http://www.nih.gov).



**Substance Abuse and Mental Health Services Administration (SAMHSA)** is responsible for reducing the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards, and improving behavioral health practice in communities, in both primary and specialty care settings. For more information, visit [www.samhsa.gov](http://www.samhsa.gov).

## ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

In addition, the following Staff Divisions (StaffDivs) report directly to the Secretary, managing programs and supporting the OpDivs in carrying out the Department's mission. The primary goal of the Department's StaffDivs is to provide leadership, direction, and policy and management guidance to the Department. The StaffDivs are:

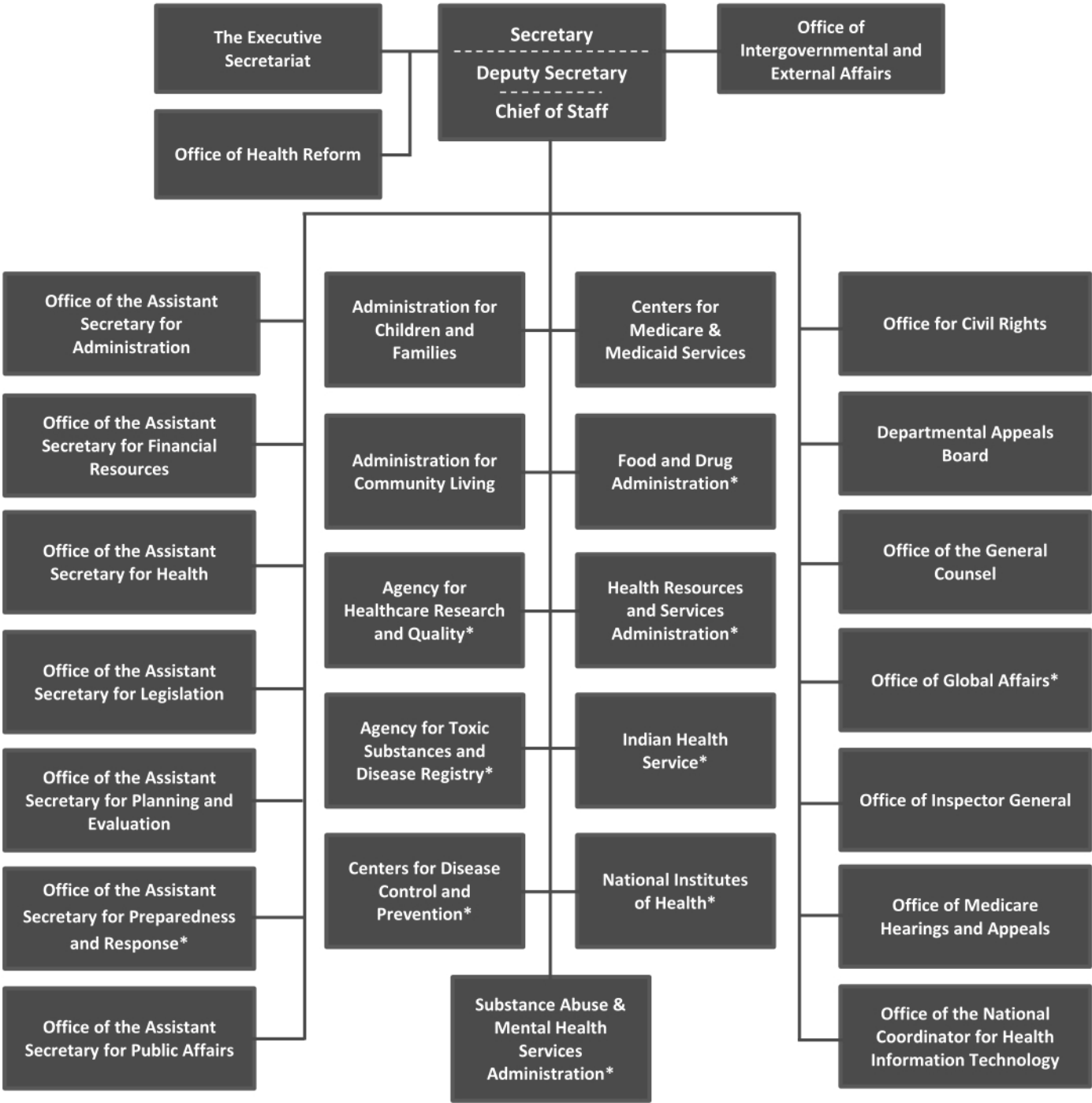
- Immediate Office of the Secretary ([www.hhs.gov/about/agencies/staff-divisions/immediate-office-secretary](http://www.hhs.gov/about/agencies/staff-divisions/immediate-office-secretary))
  - The Executive Secretariat ([www.hhs.gov/about/agencies/staff-divisions/immediate-office-secretary/executive-secretariat/index.html](http://www.hhs.gov/about/agencies/staff-divisions/immediate-office-secretary/executive-secretariat/index.html))
  - Office of Health Reform
  - Office of Intergovernmental and External Affairs ([www.hhs.gov/about/agencies/iea/index.html](http://www.hhs.gov/about/agencies/iea/index.html))
- Office of the Assistant Secretary for Administration ([www.hhs.gov/asa/index.html](http://www.hhs.gov/asa/index.html))
  - Program Support Center ([www.psc.gov/](http://www.psc.gov/))
- Office of the Assistant Secretary for Financial Resources ([www.hhs.gov/about/agencies/asfr/index.html](http://www.hhs.gov/about/agencies/asfr/index.html))
- Office of the Assistant Secretary for Health ([www.hhs.gov/ash](http://www.hhs.gov/ash))
- Office of the Assistant Secretary for Legislation ([www.hhs.gov/asl/](http://www.hhs.gov/asl/))
- Office of the Assistant Secretary for Planning and Evaluation ([www.aspe.hhs.gov/](http://www.aspe.hhs.gov/))
- Office of the Assistant Secretary for Preparedness and Response ([www.phe.gov/about/pages/default.aspx](http://www.phe.gov/about/pages/default.aspx))
- Office of the Assistant Secretary for Public Affairs ([www.hhs.gov/about/agencies/aspa/index.html](http://www.hhs.gov/about/agencies/aspa/index.html))
- Office for Civil Rights ([www.hhs.gov/ocr](http://www.hhs.gov/ocr))
- Departmental Appeals Board ([www.hhs.gov/dab/](http://www.hhs.gov/dab/))
- Office of the General Counsel ([www.hhs.gov/about/agencies/ogc/index.html](http://www.hhs.gov/about/agencies/ogc/index.html))
- Office of Global Affairs ([www.hhs.gov/about/agencies/oga](http://www.hhs.gov/about/agencies/oga))
- Office of Inspector General ([www.oig.hhs.gov/](http://www.oig.hhs.gov/))
- Office of Medicare Hearings and Appeals ([www.hhs.gov/about/agencies/omha/index.html](http://www.hhs.gov/about/agencies/omha/index.html))
- Office of the National Coordinator for Health Information Technology ([www.healthit.gov/newsroom/about-onc](http://www.healthit.gov/newsroom/about-onc))

The HHS organizational chart, which consists of the Office of the Secretary and the noted StaffDivs and OpDivs, is presented on the next page. For further information regarding our organization, components, and programs, visit our website at [www.hhs.gov](http://www.hhs.gov).



Office of the Assistant Secretary for Preparedness and Response operations experts prepare for Hurricane Matthew.

ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES



\*Component of the Public Health Service

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

### Overview of Strategic and Agency Priority Goals

Every 4 years HHS updates its strategic plan, which describes its work to address complex, multifaceted, and evolving health and human services issues. An agency strategic plan is 1 of 3 main elements required by the *Government Performance and Results Act of 1993* (GPRA) and the *GPRA Modernization Act of 2010*. The Department's Strategic Plan (Plan) defines its mission, goals, and the means by which it will measure its progress in addressing specific national problems over a four-year period. In addition, each of the Department's OpDivs and StaffDivs contribute to the development of the strategic plan, as reflected in the Plan's strategic goals, objectives, strategies, and performance goals.

### Strategic Goals

The HHS Strategic Plan FY 2014 – 2018 ([www.hhs.gov/about/strategic-plan/index.html](http://www.hhs.gov/about/strategic-plan/index.html)) describes the Department's efforts within the context of broad strategic goals. This Plan identifies 4 strategic goals and 21 related objectives. The four strategic goals are:

Goal 1: Strengthen Health Care

Goal 2: Advance Scientific Knowledge and Innovation

Goal 3: Advance the Health, Safety, and Well-being of the American People

Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

The strategic goals and associated objectives focus on the major functions of HHS. Although the strategic goals and objectives in the Plan are presented as separate sections, they are interrelated, and successful achievement of one strategic goal or objective can influence the success of others. For example, the application of a promising new scientific discovery (Strategic Goal 2) can affect the quality of health care patients receive (Strategic Goal 1) and/or the success of human service programs (Strategic Goal 3). Improving economic well-being and other social determinants of health (Strategic Goal 3) can improve health outcomes (Strategic Goal 1). Responsible management and stewardship of federal resources (Strategic Goal 4) can create efficiencies the Department can leverage to advance its health, public health, research, and human services goals. For the third consecutive year, HHS conducted an annual Strategic Review, which consisted of various senior Department leaders reviewing performance data, evidence, and other factors for the 21 objectives. The annual review allows HHS leadership to undertake a high-level look at results, challenges, and future initiatives across the Department.

### Agency Priority Goals

HHS uses Agency Priority Goals (APGs) to improve performance and accountability. HHS developed APGs by collaborating across the Department to identify activities that would reflect HHS priorities and benefit from the focus of the APG process. These goals are a set of ambitious but realistic performance objectives that the Department will strive to achieve within a 24-month period. For FY 2016 – FY 2017, HHS developed a new set of APGs. Altogether, these APGs involve work from 14 OpDivs and StaffDivs, combined. HHS is currently engaged in the following APGs that support the achievement of our strategic goals:

APG 1: Shift Medicare health care payments from volume to value

APG 2: Improve the quality of early childhood programs for low-income children

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

APG 3: Improve the timeliness of initiation into treatment for individuals with serious mental illness

APG 4: Combating antibiotic-resistant bacteria

APG 5: Reduce opioid-related morbidity and mortality

APG 6: Reduce foodborne illness

APG 7: Reduce the annual adult combustible tobacco consumption in the U.S.

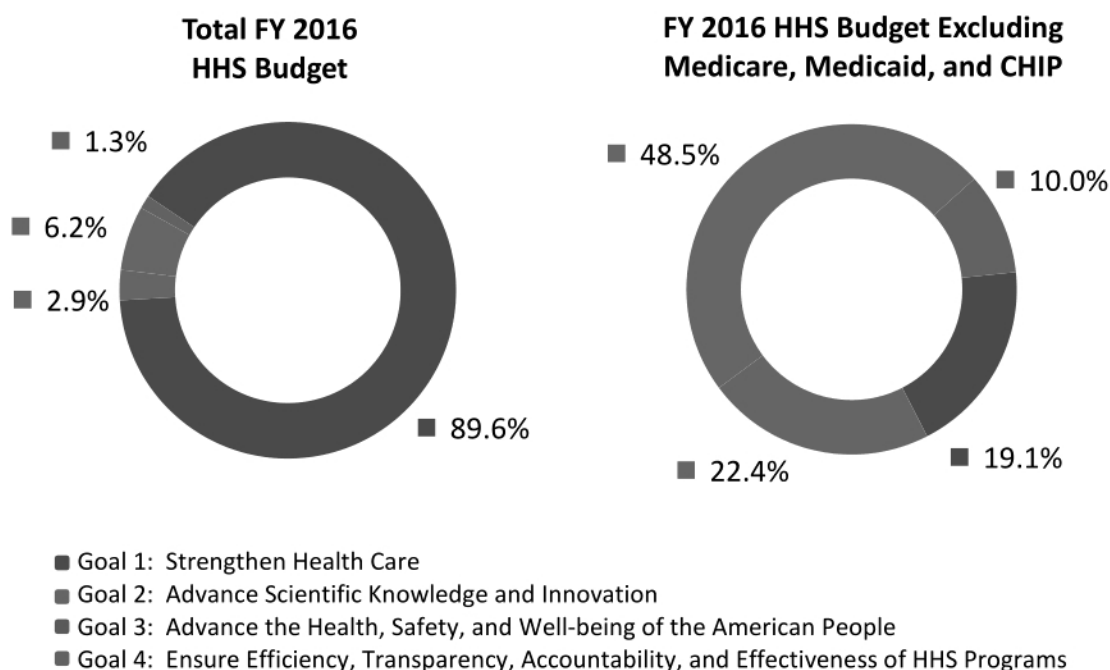
The knowledge gained through collaboration and during data-driven reviews has supported the development of our APGs. For more information on HHS's APGs, please visit [Performance.gov](http://Performance.gov) ([www.performance.gov/agency/department-health-and-human-services?view=public#apg](http://www.performance.gov/agency/department-health-and-human-services?view=public#apg)). HHS performance initiatives, including APGs, continue to influence plans and policies as demonstrated in the Department's Strategic Plan, which guides our efforts into the future.

### Looking Back at FY 2016 Performance and Budget

It is helpful to look at how HHS invests resources toward fulfilling the Department's mission through its strategic goals. Below are two charts that show the proportion of financial resources that are primarily dedicated to achieving each strategic goal.

Although HHS funding is categorized here by strategic goals, many of the programs in HHS are crosscutting in nature and support a number of strategic goals. The chart on the left provides the breakdown of the HHS budget by strategic goal. The majority of the Department's funding was primarily associated with Goal 1 because of the large amount of money invested in delivering quality care and services through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). For FY 2016, of the four strategic goals, 89.6 percent of funding was spent on Goal 1, 2.9 percent on Goal 2, 6.2 percent on Goal 3, and 1.3 percent on Goal 4.

The chart on the right illustrates the HHS FY 2016 budget excluding the costs of Medicare, Medicaid, and CHIP. Of the four strategic goals excluding Medicare, Medicaid, and CHIP, 19.1 percent was spent on Goal 1, 22.4 percent on Goal 2, 48.5 percent on Goal 3, and 10.0 percent on Goal 4.



## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

## Performance Management

HHS continues to engage with individuals across the federal performance management community to implement best practices and refine processes. These refinements and lessons learned have also influenced future plans and priorities. Refer to the “Looking Ahead to 2017” section for further details. HHS will actively monitor progress and work toward achieving our APGs through quarterly data-driven reviews and other mechanisms. The most recent data, accomplishments, and future actions on HHS APGs as well as information on previous APG cycles, can be found on Performance.gov ([www.performance.gov/agency/department-health-and-human-services](http://www.performance.gov/agency/department-health-and-human-services)). The website provides information on the measures and milestones used by HHS to track progress toward these goals.

In addition to the APGs and strategic reviews, HHS reported data on 144 performance measures in its FY 2017 *HHS Annual Performance Plan and Report*. These measures represent important issue areas being addressed by the health care and human services communities. The performance measures present a powerful tool to improve HHS operations and help to advance an effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions. While HHS does not yet have FY 2016 data available for all measures due to the lag associated with data collection and reporting of results in the FY 2016 AFR, HHS's OpDivs and StaffDivs constantly strive to find lower-cost ways to achieve positive impacts in addition to sustaining and fostering the replication of effective and efficient government programs. For more information on results from FY 2016 and earlier, please consult the *HHS Annual Performance Plan and Report* ([www.hhs.gov/about/budget/fy2017/performance/index.html](http://www.hhs.gov/about/budget/fy2017/performance/index.html)), released annually along with the *President's Budget*.

## Performance Results

The performance results in this section represent key measures and performance highlights demonstrating progress toward each HHS strategic goal.

The accomplishments and performance trends, including progress on HHS APGs, underscore HHS's dedication to sustained performance improvement and emphasis on working to meet the Department's four strategic goals. Targets presented within the tables represent performance expectations based on a number of factors and may not exceed the previous years' results, although they may represent an improvement over previous years' targets. The status row within each performance measure table indicates whether or not targets that were met or exceeded for the applicable period. Some results were not available at the time of this report due to the lag associated with data collection requirements. The target is displayed to show planned progress. More updated information will be available in the *FY 2018 Annual Performance Plan and Report* ([www.hhs.gov/about/budget](http://www.hhs.gov/about/budget)).



### Strategic Goal 1 Strengthen Health Care

#### Objectives

- 1.A. Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured
- 1.B. Improve health care quality and patient safety
- 1.C. Emphasize primary and preventive care, linked with community prevention services
- 1.D. Reduce the growth of health care costs while promoting high-value, effective care
- 1.E. Ensure access to quality, culturally competent care, including long-term services and support, for vulnerable populations
- 1.F. Improve health care and population health through meaningful use of health information technology

### Strategic Goal 1: Strengthen Health Care

The intent of the *Affordable Care Act* was to transform and modernize the American health care system. As 2016 draws to a close, HHS continues to drive the effort to strengthen and modernize health care to improve patient outcomes. Through its programs, HHS also promotes efficiency and accountability, ensures patient safety, encourages shared responsibility, and works toward high-value health care. In addition to addressing these responsibilities, HHS is improving access to culturally competent, quality health care for uninsured, underserved, and vulnerable populations.

**Health Care Payment Reform.** To build a health care system that delivers better care, that is smarter about how dollars are spent, and that makes people healthier, the *Affordable Care Act* created a number of new programs and payment models with goals of rewarding value and quality. These models include Accountable Care Organization models, medical home models focused on primary care, and new models of bundling payments for episodes of care. In these alternative payment models, health care providers are accountable for the quality and cost of the care they deliver to patients and have a

financial incentive to coordinate care for their patients – who are therefore more likely to receive high quality, team-based care. In March 2016, HHS announced that we were on track to meet the 2016 target ahead of schedule. However, HHS cannot calculate the percentage of Medicare Fee-For-Service (FFS) payments tied to quality and value until reconciled claims data are available 9 months after the end of each calendar year, leading to the significant time gap between the end of the calendar year and when results are available.

#### APG 1 – Shift Medicare health care payments from volume to value

Performance Measure: Percent of Medicare FFS payments tied to Quality and Value in Alternative Payment Models

Unit of Measurement: Percent

	2012	2013	2014	2015	2016	2017
<b>Target</b>			-	26%	30%	40%
<b>Result</b>			22%	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018
<b>Status</b>			Baseline	Pending	Pending	Pending

**Serious Mental Illness.** Individuals with serious mental illness are a high-need, high-cost population. They are frequent utilizers of emergency departments and have high rates of readmission to inpatient care, especially when co-occurring substance use disorders are present. In addition, people with serious mental illness often have comorbid physical health conditions and shorter life expectancies than people without serious mental illness, primarily due to co-occurring physical health conditions that too often go unaddressed. Individuals with serious mental illness often experience barriers to treatment, including difficulty accessing and initiating treatment. Significant delays in the identification and treatment of serious mental illness are common; for example, research has repeatedly found that individuals with psychosis in the U.S. often do not receive

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

appropriate treatment for that condition for 1 to 3 years. HHS's Serious Mental Illness Initiative builds on activities that are currently underway in various HHS agencies; these activities are coordinated through the HHS Behavioral Health Coordinating Council (BHCC). The BHCC subcommittee on serious mental illness is critical to the implementation of the Initiative, which is also oriented toward achievement of this APG on serious mental illness.

**APG 3 – Improve the timeliness of initiation into treatment for individuals with serious mental illness**

Performance Measure: Increase access to early intervention services  
by increasing the number of states with early intervention programs

*Unit of Measurement: States*

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>				-	-	20 states
<b>Result</b>				13 states	25 states	Sept 30, 2017
<b>Status</b>				Baseline	Baseline	Pending

**Combating Antibiotic-Resistant Bacteria.** Antibiotics have been a critical public health tool since the discovery of penicillin in 1928, saving the lives of millions of people around the world. Today, however, the emergence of drug resistance in bacteria is reversing the miracles of the past 80 years, with drug choices for the treatment of many bacterial infections becoming increasingly limited, expensive, and, in some cases, nonexistent. CDC estimates that drug-resistant bacteria cause two million illnesses and approximately 23,000 deaths each year in the U.S. alone. At least one-third of antibiotics used in inpatient settings are either unnecessary or inappropriately prescribed. Implementation of antibiotic stewardship programs in hospitals will help ensure that hospitalized patients receive the right antibiotic, at the right dose, at the right time, and for the right duration. Improved antibiotic use leads to reduced mortality, reduced risk of *Clostridium difficile*-associated diarrhea, shorter hospital stays, reduced overall antibiotic resistance within the hospital, and increased cost savings.

## Did you know?

Antibiotics are among the most commonly prescribed drugs used in human medicine, and can often be lifesaving. However, up to 50 percent of the time antibiotics are not optimally prescribed, often done so when not needed, or with an incorrect dosage or duration.

**APG 4 – Combating Antibiotic-Resistant Bacteria**

Performance Measure: Increasing the percent of hospitals that report implementation of antibiotic stewardship programs that comply with all of the CDC Core Elements for Hospital Antibiotic Stewardship Programs

*Unit of Measurement: Percent*

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>			-	-	50.0%	59.0%
<b>Result</b>			39.2%	40.9%	July 31, 2017	July 31, 2018
<b>Status</b>			Baseline	Baseline	Pending	Pending

**Opioid Morbidity and Mortality.** Opioid misuse and overdose present a nationwide public health challenge. Death by drug overdose is the leading cause of injury death in the U.S., with deaths from opioids in particular increasing precipitously in the twenty-first century. Overdose deaths from prescription opioids, such as oxycodone, hydrocodone, and morphine, have more than quadrupled over the period 1999 – 2013. Overdose deaths involving heroin have increased significantly in recent years, more than tripling from 2010 – 2014. Agencies across HHS recognize the urgency of halting the rise of opioid use disorder and overdose, and are working to

develop and implement the most effective interventions, from prevention through treatment. By September 30, 2017, opioid-related overdose death and opioid use disorder will be addressed through the three priority areas of reforming opioid prescribing practices, increasing the use of naloxone, and expanding access to and use of medication-assisted treatment for opioid use disorders.

**APG 5 – Reduce opioid-related morbidity and mortality**

Performance Measure: Decrease the total morphine milligram equivalents (MMEs) dispensed

*Unit of Measurement: MMEs*

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	N/A	N/A	N/A	N/A	53,237,426,263	50,435,456,459
<b>Result</b>	62,835,579,985	60,493,554,681	59,352,680,649	55,734,326,020	Nov 30, 2016	Nov 30, 2017
<b>Status</b>	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending	Pending

Performance Measure: Increase the number of prescriptions dispensed for naloxone

*Unit of Measurement: Prescriptions*

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	N/A	N/A	N/A	N/A	4,771	5,104
<b>Result</b>	396	351	2,038	7,658	Nov 30, 2016	Nov 30, 2017
<b>Status</b>	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending	Pending

Performance Measure: Increase the number of unique patients receiving prescriptions for buprenorphine (BUP) and naltrexone (NAL) in a retail setting

*Unit of Measurement: Patients*

	FY 2012	FY 2013	FY 2014 (BUP)	FY 2014 (NAL)	FY 2015 (BUP)	FY 2015 (NAL)	FY 2016 (BUP)	FY 2016 (NAL)	FY 2017 (BUP)	FY 2017 (NAL)
<b>Target</b>			N/A	N/A	N/A	N/A	915,207	112,398	958,788	117,750
<b>Result</b>			807,555	85,494	909,656	121,067	Nov 30, 2016	Nov 30, 2016	Nov 30, 2017	Nov 30, 2017
<b>Status</b>			Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending	Pending	Pending	Pending

## Did you know?

In 2015, nearly 2.4 million Americans had an opioid use disorder, and close to 80 percent of them did not receive treatment.

**AHRQ's Patient Safety Network (PSNet).** AHRQ PSNet ([psnet.ahrq.gov](http://psnet.ahrq.gov)) is a web-based resource featuring the latest news and essential information on patient safety. In 2001, AHRQ launched a web-based morbidity and mortality conference called WebM&M to facilitate the posting of anonymous cases of medical errors or near misses, accompanied by commentaries written by experts that articulated lessons learned in a thoughtful, evidence-based, and engaging way. Over the nearly 15-year existence of WebM&M, the site has received millions of visits, awarded nearly 70,000 hours of CME credit, and published over 360 cases which have been widely used in teaching.

In the first 6 months of 2016, the new AHRQ PSNet has already received almost 600,000 visits. User responses to the site's last satisfaction survey are overwhelmingly positive: 92 percent of PSNet and 86 percent of WebM&M respondents stated they were likely to recommend these sites as resources on patient safety. Supported by a robust patient safety taxonomy and web architecture, AHRQ PSNet provides powerful searching and browsing capability, as well as the ability for diverse users to customize the site around their interests.

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

**Strategic Goal 2: Advance Scientific Knowledge and Innovation**

HHS is expanding its scientific understanding of how best to advance health care, public health, human services, and biomedical research, and to ensure the availability of safe medical and food products. Chief among these efforts is the identification, implementation, and rigorous evaluation of new approaches in science, health care, public health, and human services. These efforts encourage efficiency, effectiveness, sustainability, and sharing or translating that knowledge into better products and services.

**Data for evidence-based decision making.** In FY 2015, CDC published over 250 Morbidity and Mortality Weekly Reports (MMWRs) and increased total electronic media reach to 23.0 million potential viewings. The MMWR series provides critical epidemiological data and recommendations to clinicians, epidemiologists, laboratorians, and other public health professionals. Fifty-two reports were published regarding Ebola, with the publications serving as critical CDC tools for disseminating scientific and public health information about the international Ebola response. CDC also published several MMWRs regarding laboratory practices and capacity, including Competency Guidelines for Public Health Laboratory Professionals. In FY 2016, in support of the international Zika response, CDC published 34 reports regarding Zika, serving as critical CDC tools for disseminating guidance and scientific and public health information. Also in FY 2016, the MMWR publication received its first Journal Impact Factor, which measures the impact of a publication based on the frequency articles are cited. It was ranked second of the 170 journals in the category of Public, Environmental and Occupational Health. Since January 2016, CDC has released 26 scientific resources and guidance documents related to transmission, control, and treatment of the Zika virus disease in the MMWR.

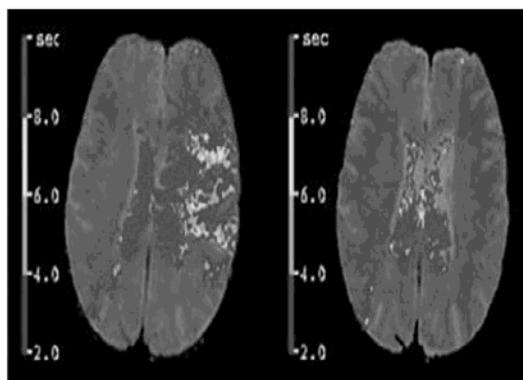
**Strategic Goal 2**  
**Advance Scientific Knowledge and Innovation**
Objectives

- 2.A Accelerate the process of scientific discovery to improve health
- 2.B Foster and apply innovative solutions to health, public health, and human services challenges
- 2.C Advance the regulatory sciences to enhance food safety, improve medical product development, and support tobacco regulation
- 2.D Increase our understanding of what works in public health and human services practice
- 2.E Improve laboratory, surveillance, and epidemiology capacity



CDC microbiologist works with a test developed for the Zika virus response.

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS



NIH DEFUSE-2 MRI brain scans from a stroke patient, illustrating improved blood flow. The MRI helps doctors determine the most effective therapy approach; over the next month, this patient made a nearly complete recovery.

**New imaging methods for post-stroke care.** The blood-brain barrier is a layer of cells that protects the brain from harmful molecules passing through the bloodstream. After stroke, the barrier is disrupted, becoming permeable and losing control over what gets into the brain. In a study of stroke patients, NIH investigators confirmed through magnetic resonance imaging (MRI) brain scans that there was an association between the extent of disruption to the blood-brain barrier and the severity of bleeding following invasive stroke therapy. These findings are part of the Diffusion and Perfusion Imaging Evaluation for Understanding Stroke Evolution (DEFUSE)-2 Study, which was designed to see how MRIs can help determine which patients undergo endovascular therapy (removing a blood clot or breaking it up with a stent) following ischemic stroke. Ischemic stroke patients are increasingly receiving combination therapy, endovascular treatment along with an intravenous drug known as tissue plasminogen activator (t-PA), to effectively break up clots in the brain. However, bleeding into the damaged brain tissue is a serious complication of both acute stroke therapies. This research has led to a large phase III clinical trial, currently being conducted in the NIH Stroke Network, to evaluate the role of these imaging techniques in identifying patients likely to benefit from new approaches to endovascular therapy.

**International Field Epidemiology Training Programs.** Since 1980, CDC has developed international Field Epidemiology Training Programs (FETPs) serving over 70 countries that have graduated over 3,600 epidemiologists. Through FETPs, CDC helps establish a network of disease detectives around the globe that are the first line of defense in detecting and responding to outbreaks in their respective countries as well as neighboring countries. In FY 2015, CDC exceeded its target for new residents by more than 20 percent over FY 2014, a nearly 75 percent increase since FY 2012. On average, over 80 percent of FETP graduates work within their Ministry of Health after graduation and many assume key leadership positions, such as the National Director of Tuberculosis program and National Director of Chronic Disease program in the Dominican Republic. The total number of new FETP residents increased in FY 2015 to 483, strengthening global health ministries' ability to detect and respond to outbreaks. Their presence enhances sustainable public health capacity in these countries, which is critical in transitioning U.S.-led global health investments to long-term host-country ownership. CDC is planning for a level number of new residents in FY 2017 based on current participation and funding considerations. FETP activities are supported by funding from CDC appropriations and inter-agency agreements with the Department of Defense, Department of State, and the U.S. Agency for International Development. Policy changes within those agencies may affect the future number of FETPs supported, which may require adjustments to targets.

Performance Measure: Increase epidemiology and laboratory capacity within global health ministries through the FETP New Residents

Unit of Measurement: New Residents

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	179	255	430	430	430	430
<b>Result</b>	280	300	402	483	June 30, 2017	June 30, 2018
<b>Status</b>	Target Exceeded	Target Exceeded	Target Not Met but Improved	Target Exceeded	Pending	Pending

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

**Strategic Goal 3: Advance the Health, Safety, and Well-Being of the American People**

HHS strives to promote the health, economic, and social well-being of children, people with disabilities, and older adults while improving wellness for all. To meet this goal, the Department is employing evidence-based strategies to strengthen families and to improve outcomes for children, adults, and communities. A focus on prevention underlies each objective and strategy associated with this goal.

**Quality Rating and Improvement Systems with High-Quality Benchmarks.** The “Improve the quality of early childhood programs for low-income children” APG ([www.performance.gov/content/improve-quality-early-childhood-programs-low-income-children](http://www.performance.gov/content/improve-quality-early-childhood-programs-low-income-children)) calls for actions to improve the quality of programs for children of low-income families, namely Head Start and Child Care. For the Child Care program, the aim is to increase the number of states with Quality Rating and Improvement Systems (QRIS) that meet the seven high quality benchmarks for child care and other early childhood programs developed by HHS. QRIS is a mechanism used to improve the quality of child care available in communities and to increase parents’ knowledge and understanding of available child care options. Through FY 2015, 32 states had a QRIS that met high-quality benchmarks, meeting the APG target. States expanded from pilot programs to state-wide systems, added financial incentives for child care providers, and increased availability of quality information, leading them to meet more components of the QRIS measure.

**Strategic Goal 3**  
Advance the Health, Safety and Well-being of  
the American People

Objectives

- 3.A Promote the safety, well-being, resilience, and healthy development of children and youth
- 3.B Promote economic and social well-being for individuals, families, and communities
- 3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults
- 3.D Promote prevention and wellness across the life span
- 3.E Reduce the occurrence of infectious diseases
- 3.F Protect Americans’ health and safety during emergencies, and foster resilience to withstand and respond to emergencies

**APG 2 - Improve the quality of early childhood programs for low-income children**

Performance Measure: Increase the number of states with QRIS that meet high quality benchmarks for child care and other early childhood programs developed by HHS

*Unit of Measurement: States*

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	20 states	25 states	29 states	32 states	35 states	37 states
<b>Result</b>	19 states	27 states	29 states	32 states	June 30, 2017	June 30, 2018
<b>Status</b>	Target Not Met but Improved	Target Exceeded	Target Met	Target Met	Pending	Pending

**Reduction in Head Start Grantees Receiving a Low Score on the Classroom Assessment Scoring System (CLASS: Pre-K).** In support of this APG, ACF is striving to increase the percentage of Head Start children in high quality classrooms. Progress is measured by reducing the proportion of Head Start grantees that score in the low range on any of the three domains of the CLASS: Pre-K, a research-based tool that measures teacher-child interaction on a seven-point scale in three broad domains: Emotional Support, Classroom Organization, and Instructional Support. An analysis of CLASS scores for FY 2016 indicates that 24 percent of grantees scored in the low range, exceeding the target of 25 percent. All grantees scoring in the low range did so on the Instructional Support domain.

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

ACF continues to invest in building its CLASS related resources and making those resources available to grantees. In response to the data from the FY 2013 CLASS reviews, ACF provides more intentional targeted assistance to those grantees that score in the low range on CLASS. ACF continues to conduct more analysis on the specific dimensions that are particularly challenging for those grantees, such as concept development and language modeling, and tailor the technical assistance for grantees based on their specific needs.

A recent analysis of data from the Family and Child Experience Survey (FACES), a federally funded nationally representative survey of Head Start programs, provides some evidence that grantee scores on domains of the CLASS have improved over time. This analysis demonstrates that over time fewer classrooms scored in the “low” range and more classrooms scored in the “mid” to “high” range on Instructional Support. FACES data also shows a statistically significant increase in the average score and the percentage of Head Start classrooms scoring 3 or higher on Instructional Support between 2006 and 2014. Overall, Head Start classrooms regularly score above a 5 in Emotional Support and Classroom Organization. The FACES data analysis showed that over time fewer classrooms scored in the “mid” range and more classrooms scored in the “high” range on Emotional Support.

**APG 2 - Improve the quality of early childhood programs for low-income children**

Performance Measure: Reduce the proportion of Head Start grantees

receiving a score in the low range on the basis of CLASS: Pre-K

*Unit of Measurement: Percent*

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	-	23%	27%	26%	25%	24%
<b>Result</b>	25%	31%	23%	22%	24%	Jan 31, 2018
<b>Status</b>	Baseline	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending

## Did you know?

Head Start helps families obtain health insurance, find services for children with disabilities, secure adequate housing, participate in job training, and more.

**Head Start Teachers with Degrees in Early Childhood Education.** In addition to looking at classroom quality through the CLASS measure, the ACF Office of Head Start (OHS) is also emphasizing the credentials of classroom teachers by striving to increase the percentage of Head Start and Early Head Start teachers with a Bachelor's Degree (BA) degree. In doing so, OHS is prioritizing a distinct but complementary goal in boosting the quality of Head Start programs. This measure is distinct in that it looks at credentials for both Head Start and Early Head Start teachers, rather than focusing on the credentials of Head Start pre-school teachers. The most recent results for this performance measure indicate that in FY 2016, 55 percent of Head Start and Early Head Start teachers have a BA or higher, missing the target of 62 percent.

Analysis of the data indicates that a key reason for the decrease relative to the prior year is that a lower percentage of teachers in Early Head Start-Child Care partnership (EHS-CCP) programs have BA degrees. This year is the first year the Program Information Report, the annual survey of Head Start grantees, collects data on these teachers, which has an effect on our national average. The purpose of the EHS-CCP grants is to improve the care of infants and toddlers through partnerships with Early Head Start programs and child care programs that agree to

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

meet the Head Start Program Performance Standards, which includes requirements for teacher qualifications. We anticipate qualifications will increase through these continued partnerships.

To continue the trend of increasing the number of teachers with a BA or higher, ACF is investing in an initiative called Early EdU, which is a higher education alliance working to advance early childhood teaching by providing online courses for early childhood educators so they can pursue a BA. ACF is also working within states to strengthen early care and education professional development systems and promote articulation agreements within and across institutions of higher education. Articulation agreements allow students to apply credits earned in one program toward another program, which facilitates them moving along their educational pathway toward a BA.

**APG 2 - Improve the quality of early childhood programs for low-income children**

Performance Measure: Increase the percentage of teachers in Head Start and Early Head Start that have a BA or higher

*Unit of Measurement: Percent*

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	N/A	N/A	N/A	N/A	62%	57%
<b>Result</b>	52%	55%	58%	60%	55%	Jan 31, 2018
<b>Status</b>	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Target Not Met	Pending

**Reduce Foodborne Illness.** *Listeria monocytogenes* (L.m.) infections are one of the leading causes of death from foodborne illness in the U.S., resulting in an estimated 1,600 illnesses and 260 deaths each year. Outbreak investigations determine which foods are responsible for illness and can lead to important food safety improvements. For example, recent investigations identified previously unknown sources of L.m. illnesses—cantaloupe, ice cream, and caramel apples—and focused attention on preventing contamination of these products. However, finding the source of clusters of L.m. illnesses is difficult. Determining if the same strain of L.m. is making people sick, meaning the illnesses likely came from the same food source, requires intensive investigation. Clusters of illnesses caused by L.m. strains with the same genetic fingerprint are often small. Figuring out what ill persons ate in common is often very difficult; especially when some are too sick for interviews or have died and the long incubation period makes it more difficult for patients to remember what and where they ate. More complete information from patient interviews, information about isolations of L.m. from food and the environment, and whole genome sequencing of strains can all help to identify the source of outbreaks. When food sources and the cause of contamination are identified, food safety changes can be implemented throughout an industry and prevent future outbreaks.



A member of the FDA Whole Genome Sequencing Team in a lab.



**APG 6 – Reduce Foodborne Illness**

Performance Measure: Reduce the incidence rate of Listeria

Unit of Measurement: Reported Cases per 100,000 population per year

	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
<b>Target</b>	-	-	-	-	-	.22 cases/100,000
<b>Result</b>	.26 cases/100,000	.25 cases/100,000	.24 cases/100,000	.24 cases/100,000	March 31, 2017	March 31, 2018
<b>Status</b>	Baseline	Baseline	Baseline	Baseline	Pending	Pending

**Combustible Tobacco Consumption (Cigarette Equivalents).** Smoking and secondhand smoke kill an estimated 480,000 people in the U.S. each year. For every smoker who dies from a smoking-attributable disease, another 30 live with a serious smoking-related disease. Smoking costs the U.S. \$170 billion in medical costs and \$156 billion in lost productivity each year. An estimated 58 million nonsmoking Americans are exposed to secondhand smoke, which causes more than 41,000 deaths in non-smoking adults each year. While smoking among adults in the U.S. has decreased significantly from a decade ago, the decline in adult smoking rates has slowed, concurrent with reductions in state investments in tobacco control programs. In addition, the coordinated efforts of the APG to reduce tobacco use ([www.performance.gov/content/reduce-annual-adult-combustible-tobacco-consumption-united-states](http://www.performance.gov/content/reduce-annual-adult-combustible-tobacco-consumption-united-states)) have resulted in reductions in adult cigarette consumption, based on FY 2013 results (reported in June 2014). For FY 2015, the annual per capita adult cigarette consumption fell to 1,211 cigarettes, but missed the FY 2015 target of 1,174 (37 cigarette equivalents). However, the FY 2014 results (the most recent available data) of other combustible tobacco use indicators are tracking lower usage across both adults and youth:

- Percentage of adult smokers – 16.8 percent; exceeding the FY 2014 target of 18 percent (National Health Interview Survey)
- Percentage of adult smokers who last smoked 6 months to 1 year ago – 7.6 percent; exceeding the FY 2014 target of 7.2 percent (National Health Interview Survey)
- Percentage of children/adolescents initiation – 3.8 percent; exceeding the FY 2014 target of 4.7 percent (National Survey on Drug Use and Health)
- Percentage of young adults initiation – 7.2 percent; exceeding the FY 2014 target of 7.5 percent (National Survey on Drug Use and Health)

CDC plans to continue conducting applied research on the health effects and patterns of use of emerging tobacco products to inform the American public as well as decision makers. CDC is also modifying its surveillance systems to ensure it is able to capture relevant data on new products and shifting patterns of use. CDC will continue to communicate about these evolving issues to the American public, through media, such as the Tips from Former Smokers national education campaign.

**APG 7 - Reduce the annual adult combustible tobacco consumption in the United States**

Performance Measure: Annual Per Capita Combustible Tobacco Consumption by Adults in the U.S.

Unit of Measurement: Cigarette Equivalents per Capita

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	-	1,259 per capita	1,212 per capita	1,174 per capita	1,145 per capita	1,127 per capita
<b>Result</b>	N/A	1,277 per capita	1,216 per capita	1,211 per capita	July 31, 2017	July 31, 2018
<b>Status</b>	Set Baseline	Target Not Met	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

**National Family Caregiver Support Program.** Families are the nation's primary provider of long-term care, but a number of factors including financial constraints, work and family demands, and the many challenges of providing care places great pressure on family caregivers. Better support for informal caregivers is critical because often it is their availability that determines whether an older person can remain in his or her home. In 2013, approximately 34.2 million adult caregivers provided uncompensated care to those 50 years and older. The economic cost of replacing unpaid caregiving of elderly adults is estimated to be between \$470 billion and \$522 billion annually. ACL's Administration on Aging Family Caregiver Support Program provides services and supports that lessen the strain and make caregiving easier for family caregivers, such as information, counseling and training, respite care and supplemental services. Since 2008, program participants have rated services good to excellent consistently above the target level of 90 percent. Nearly 75 percent of program participants reported that services enabled them to provide care longer than otherwise would have been possible and the same percent report feeling less stressed due to services. It should also be noted that results of an ACL evaluation of the National Family Caregiver Support Program (NFCSP) show that states reported being able to serve greater numbers of family caregivers as a result of the NFCSP. This includes a 260 percent increase, from before the NFCSP was implemented, in support group services (an increase from 15 to 54 states) and a 227 percent increase in training and education services for caregivers (an increase from 15 to 49 states). Of 53 reporting states, about half (45 percent) answered that the NFCSP is the only state-administered caregiver program.

Performance Measure: Maintain at 90% or higher the percentage of NFCSP clients who rate services good to excellent

Unit of Measurement: Percent

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	90%	90%	90%	90%	90%	90%
<b>Result</b>	93.8%	94.6%	93.6%	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
<b>Status</b>	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending



Caregiver with family member. The *Older Americans Act Reauthorization Act of 2016* was signed into law in April 2016. It includes a key change to NFCSP, allowing the program to be more inclusive in serving older-relative caregivers, including people who are age 55 or older and parents of individuals with disabilities.

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

**Strategic Goal 4**  
**Ensure Efficiency, Transparency, Accountability,**  
**and Effectiveness of HHS Programs**

**Objectives**

- 4.A Strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud, and integrating financial, performance, and risk management**
- 4.B Enhance access to and use of data to improve HHS programs and to support improvements in the health and well-being of the American people**
- 4.C Invest in the HHS workforce to help meet America's health and human services needs**
- 4.D Improve HHS environmental, energy, and economic performance to promote sustainability**

**Strategic Goal 4: Ensure Efficiency, Transparency, and Accountability of HHS Programs**

As the largest grant-awarding agency in the federal government and the nation's largest health insurer, HHS places a high priority on ensuring the integrity of its expenditures. HHS manages hundreds of programs in basic and applied science, public health, income support, child development, and health and social services, which award over 75,000 grants annually. The Department has robust processes in place to manage the resources and information employed to support programs and activities.

**Medicare, Medicaid, and CHIP Improper Payment Rates.** One of CMS's key goals is to pay Medicare claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. Paying correctly the first time saves resources required to recover improper payments and

ensures the proper expenditure of valuable dollars. The primary cause of improper payments is Documentation and Administrative Errors, in large part due to insufficient documentation. Other notable causes include Authentication and Medical Necessity Errors, caused by medically unnecessary services, and to a lesser extent, incorrect diagnosis coding. Between FY 2009 and FY 2012, the improper payment rate for Medicare FFS consistently improved. Data from FY 2013 and FY 2014 indicate an increase in this improper payment rate and efforts are currently in progress to investigate and resolve the drivers causing this increase. However, the improper payment rate for Medicare FFS decreased from FY 2014 through FY 2016.

Since roughly one third of the states are measured each year to calculate the Medicaid and CHIP error rates, these measures are calculated as a rolling rate that includes the reporting year and the previous two. In an attempt to reduce the national Medicaid error rates, states are required to develop and submit corrective action plans. The FY 2016 Medicaid error rate is 10.48 percent, and the FY 2016 CHIP error rate is 7.99 percent. Similar to recent years, the increase was due to state difficulties bringing systems into compliance with new requirements for: (1) all referring or ordering providers to be enrolled in Medicaid, (2) states to screen providers under a risk-based screening process prior to enrollment, and (3) the inclusion of the attending provider National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen the integrity of the program, they require systems changes and, therefore, many states had not fully implemented these new requirements. CMS is working with states to improve compliance with the additional state requirements that contributed to the increase in error rates.

**Performance Measure: Estimate of the Improper Payment Rate in the Medicaid Program**

*Unit of Measure: Percent*

	<b>FY 2012</b>	<b>FY 2013</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY 2016</b>	<b>FY 2017</b>
<b>Target</b>	7.4%	6.4%	5.6%	6.70%	11.53%	9.57%
<b>Result</b>	7.1%	5.8%	6.7%	9.78%	10.48%	Nov 15, 2017
<b>Status</b>	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded	Pending

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

Performance Measure: Reduce the Percentage of Improper Payments  
Made Under the Medicare FFS Program

Unit of Measurement: Percent

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	5.4%	8.3%	9.9%	12.50%	11.50%	10.40%
<b>Result</b>	8.5%	10.1%	12.7%	12.09%	11.00%	Nov 15, 2017
<b>Status</b>	Target Not Met but Improved	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Pending

Performance Measure: Estimate the Percentage of Improper Payments in the CHIP Program

Unit of Measurement: Percent

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>				6.50%	6.81%	7.38%
<b>Result</b>				6.80%	7.99%	Nov 15, 2017
<b>Status</b>				Target Not Met	Target Not Met	Pending

**Clients Served by Home and Community-Based Services.** A foundation of ACL's program success is access to Home and Community-based Services. In FY 2014, the Aging Services Network served 8,930 clients per million dollars of *Older Americans Act* funding, exceeding the target of 8,600 clients per million dollars. Performance has largely trended upward and performance targets have been consistently achieved. This reflects strong partnerships with state and local governments, philanthropic organizations, and private donors that contribute funding (leveraging resources of two to three dollars for every federal dollar) and the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers, along with increased commitments and partnerships at the state and local levels, have all had positive impacts on program efficiency. Between FY 2008 and FY 2013 performance has improved by 18.3 percent, without benefit of adjustment for inflation. The FY 2014 results showed a decline while still exceeding the target. This variation between FY 2014 and FY 2017 is anticipated as delayed effects of sequestration may occur.

Performance Measure: For Home and Community-based Services including Nutrition and Caregiver services increase the number of clients served per million dollars of Title III *Older Americans Act* funding

Unit of Measurement: Number of Clients

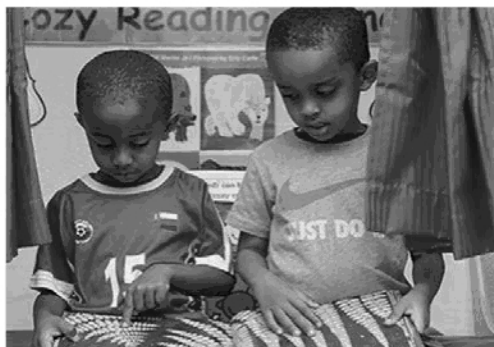
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	8,600 clients	8,700 clients	8,600 clients	9,250 clients	8,700 clients	9,000 clients
<b>Result</b>	9,206 clients	9,753 clients	8,930 clients	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
<b>Status</b>	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

**Head Start Enrollment Rate.** ACF's Head Start program works to ensure that the maximum number of children are served and that federal funds are used appropriately and efficiently by measuring under-enrollment across programs. Since Head Start grantees range in size from super-grantees with multiple delegate agencies serving up to 20,000 children to individual centers that serve as few as 15 children, a national under-enrollment rate better captures the under-enrollment than the proportion of grantees that meet under-enrollment targets. An un-enrolled space or vacancy in Head Start is defined as a funded space that is vacant for over 30 days.

ACF continues to focus on improvements to reduce Head Start under-enrollment. Though each Head Start program is required to keep a wait list to fill vacancies as they occur, there are a number of reasons that it may be difficult to fill vacancies quickly. Low-income families are often mobile and eligible families on the waiting list may have moved out of the service area. In addition, as state pre-kindergarten programs have grown, parents may choose to send their children to those programs. The most recent data available indicate that, during the 2014 –

## PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

2015 program year, Head Start grantees had, on average, not enrolled 1.84 percent of the children they were funded to serve. This represents approximately 16,700 children who could have been served using the Head Start funds appropriated and awarded to grantees.



Children at a Head Start Program.

There are three factors that contributed to the increased rate of under-enrollment in Head Start in FY 2015: (1) a period of under-enrollment as more programs become Birth-to-Five through competition and renovate facilities, train staff and recruit infants and toddlers; (2) competitive transitions which can result in a period of under-enrollment as programs become fully operational; and (3) under-enrollment within some very large grantees. The ACF OHS is following up and providing technical assistance to ensure these grantees become fully enrolled as soon as possible. Per the 2007 reauthorization of the *Head Start Act*, ACF now collects online enrollment data on a monthly basis from all Head Start grantees through the Head Start Enterprise System. The Head Start Enterprise System provides a system-generated alert when grantees are under-enrolled, and Regional Offices have procedures in place, consistent with the *Head Start Act*, to begin technical assistance and to establish improvement plans with clear timetables if the under-enrollment persists.

Performance Measure: Decrease under-enrollment in Head Start programs, thereby increasing the number of children served per dollar

Unit of Measurement: Percent

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>Target</b>	0.7%	0.7%	0.6%	0.8%	1.2%	1.1%
<b>Result</b>	0.8%	0.7%	0.9%	1.84%	Jan 31, 2017	Jan 31, 2018
<b>Status</b>	Target Not Met	Target Met	Target Not Met	Target Not Met	Pending	Pending

### Cross-Agency Priority Goals

Cross-Agency Priority goals address the longstanding challenge of tackling horizontal problems across vertical organizational silos. In the 2015 *President's Budget*, 15 Cross-Agency Priority Goals were announced – 7 mission-oriented and 8 management-focused goals with a 4-year time horizon. Established by the *GPRA Modernization Act of 2010*, these Cross-Agency Priority Goals are a tool used by federal leadership to accelerate progress on a limited number of Presidential priority areas where implementation requires active collaboration between multiple agencies. HHS contributes to Cross-Agency Priority Goals with other federal agencies in the mission-oriented goals of Science, Technology, Engineering and Mathematics Education; and Service Members and Veterans Mental Health. We are also maximizing federal spending through participation in the management-focused goals of Shared Services; Benchmark and Improve Mission-Support Operations; and Customer Service. For more information on HHS's contributions to Cross-Agency Priority Goals and progress, refer to [www.performance.gov/cap-goals-list](http://www.performance.gov/cap-goals-list).

## SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROL

### Systems

#### *Financial Systems Environment*

HHS's Chief Financial Officer (CFO) Community strives to provide effective stewardship of taxpayer funds through transparency and accountability in support of the Department's mission and programs. The HHS financial systems environment forms the financial and accounting foundation for managing the \$1.7 trillion in budgetary resources entrusted to the Department in FY 2016. These resources represent about a quarter of all federal outlays and encompass more grant dollars than all other federal agencies combined.

The robust financial systems environment supports HHS's diverse portfolio of mission-oriented programs, as well as business operations. Its purpose is to: efficiently process financial transactions in support of program activities and HHS's mission; provide complete and accurate financial information for decision-making; improve data integrity; strengthen internal controls; and mitigate risk.

The HHS financial systems environment consists of a core financial system (with three instances) and two Department-wide reporting systems used for financial and managerial reporting that – taken together – satisfy the Department's financial accounting and reporting needs.

#### *Core Financial System*

The core financial system operates on a commercial off-the-shelf (COTS) platform to support data standardization and facilitate Department-wide reporting. Each of the instances operates the same COTS solution.

- The Healthcare Integrated General Ledger Accounting System (HIGLAS) supports CMS. HIGLAS serves CMS's Medicare Administrative Contractor organizations, Administrative Program Accounting, and the Center for Consumer Information and Insurance Oversight. It processes an average of five million transactions daily.
- The NIH Business System (NBS) serves NIH's 27 research institutes and supports grant funding to more than 300,000 researchers at more than 2,500 universities, medical schools, and other research institutions in every state and around the world.
- The Unified Financial Management System (UFMS) serves 10 OpDivs (including the OS) and 18 StaffDivs across the Department. The following accounting centers utilize UFMS: CDC, FDA, IHS, and PSC. PSC provides shared service accounting support for the rest of the Department.

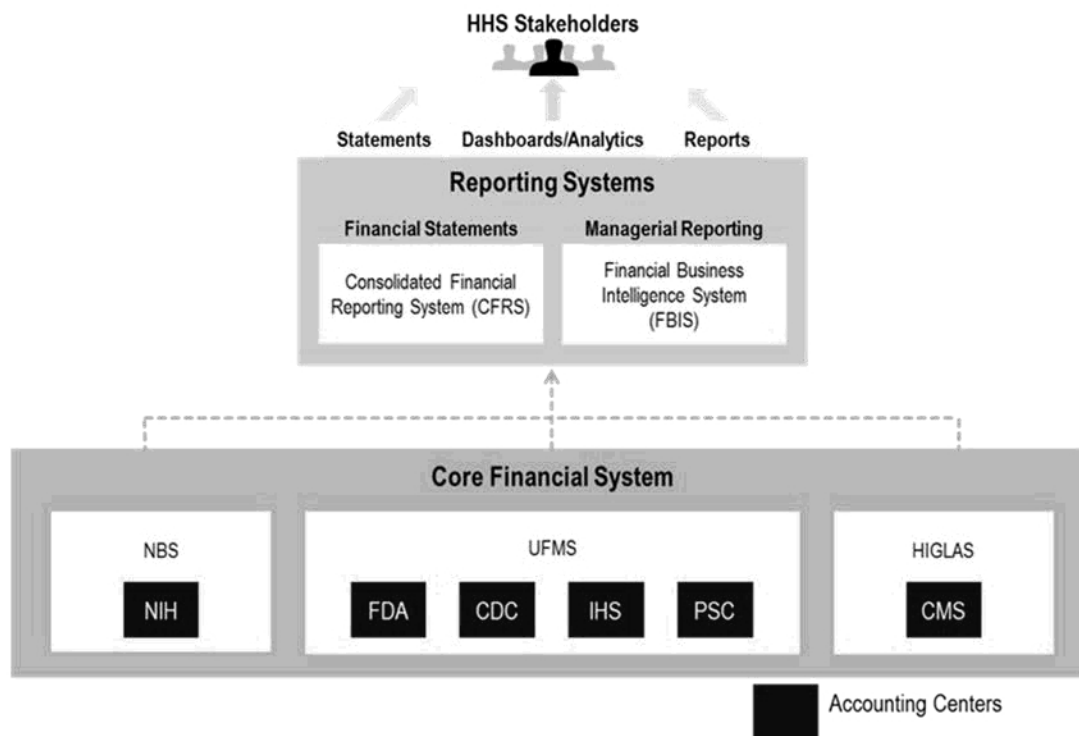
#### *Reporting Systems*

Reporting components within the HHS financial systems environment consist of two Department-wide applications: the Consolidated Financial Reporting System (CFRS) and the Financial Business Intelligence System (FBIS). These reporting systems facilitate data reconciliation, financial and managerial reporting, and data analysis.

- CFRS systematically consolidates information from all three instances of the core financial system. It generates Departmental quarterly and year-end consolidated financial statements on a consistent and timely basis, while supporting HHS in meeting regulatory reporting requirements.
- FBIS is the financial business intelligence application that supports the information needs of HHS stakeholders at all levels by retrieving, combining, and consolidating data from the core financial system. It contains a set of techniques and tools for analyzing data and presenting actionable information

including metrics and key performance indicators, dashboards with graphical displays, interactive reports, and ad-hoc reporting. FBIS allows executives, managers, and operational end users, to make informed business decisions to support their organization's mission.

The illustration below depicts the current financial systems environment.



The HHS financial systems environment is required to comply with all relevant federal laws, regulations, and authoritative guidance. In addition, HHS must conform to federal financial management and systems requirements including:

- *Federal Managers' Financial Integrity Act of 1982 (FMFIA)*
- *Chief Financial Officers Act of 1990 (CFO Act)*
- *Government Management Reform Act of 1994*
- *Federal Financial Management Improvement Act of 1996 (FFMIA)*
- *Clinger-Cohen Act of 1996*
- *Federal Information Security Management Act of 2002, as amended by the Federal Information Security Modernization Act of 2014 (FISMA)*
- *Digital Accountability and Transparency Act of 2014 (DATA Act)*
- *Federal Information Technology Acquisition Reform Act of 2014 (FITARA)*
- Office of Management and Budget (OMB) directives and U.S. Department of the Treasury (Treasury) guidance related to these laws

#### **Financial Systems Environment Improvement Strategy**

HHS continues to implement a Department-wide strategy to advance its financial systems environment through the Financial Systems Improvement Program (FSIP) and Financial Business Intelligence Program (FBIP). The portfolio of projects within these programs addresses immediate business needs and positions the Department to

## SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROL

take advantage of state-of-the-art tools and technology. The goals of the strategy are to improve the effectiveness and efficiency of the Department's financial management capabilities, mature the overall financial systems environment, and strengthen accountability and financial stewardship. This is a multi-year initiative, and the Department is making significant progress in each of the following key strategic areas.

### Financial Systems Modernization

- *Strategy:* A critical component of the multi-year FSIP initiative is upgrading the core financial system to the most current version of the COTS software to maintain a secure and reliable financial systems environment. Concurrently, HHS also plans to transition key financial systems to a cloud service provider for hosting and application management. Benefits of the upgrade and cloud transition include: safeguarding system security and privacy; enhancing information access; complying with and implementing evolving federal requirements; achieving efficiencies and promoting standardization; eliminating security and control vulnerabilities; and maximizing the return on existing system investments. Following the upgrade, additional modernization projects and enhancements to further mature the HHS financial systems environment will be pursued incrementally.
- *Progress:* HHS completed the major upgrade of its core financial system in December 2015 – on-time, on-budget, fully functional, and in-line with the federal government's broader financial management and information technology (IT) priorities. The upgrade represents one of the largest successful financial systems modernization efforts across the entire federal government. UFMS, FBIS, and CFRS were transitioned to a FedRAMP-certified cloud service provider as part of the upgrade, with plans to transition additional systems in future years, supporting both the *Federal Cloud Computing Strategy* and the *Federal Information Technology Shared Services Strategy*. The upgrade and cloud transition increase system security, scalability, reliability, and availability, and establish a shared platform configured to HHS's business needs. Further, as part of the upgrade, HHS implemented a Department-wide Accounting Treatment Manual (ATM) to improve financial reporting and fiscal accountability. With the upgrade complete, HHS is progressing on its financial systems modernization roadmap, having initiated projects to develop a Department-wide electronic invoicing solution and an automated, sustainable solution for implementing DATA Act reporting requirements.

### Business Intelligence and Analytics

- *Strategy:* Leveraging the FBIS platform, HHS is expanding the use of business intelligence and analytics across the Department to establish an information-driven financial management environment in which stakeholders at all levels have access to timely and accurate information required for measuring performance, increasing transparency, and enhancing decision-making. This will allow the Department to more effectively and efficiently meet evolving information demands for fiscal accountability, performance improvement, and external compliance requirements in a sustainable manner.
- *Progress:* Since it was first deployed in FY 2012, FBIS has been providing operational and business intelligence to users across the HHS finance, budget, grants, and acquisition communities. FBIS includes accurate, consistent, near real-time data from UFMS, and summary data from HIGLAS and NBS. FBIS now supports over 2,000 users across the Department. In FY 2016, HHS successfully consolidated several legacy managerial reporting solutions into FBIS, allowing the Department to retire three systems as reports and users were brought onto the FBIS platform. The transition to the cloud environment will facilitate further system growth, enabling FBIS to incorporate data from additional systems and business domains and generate actionable insights.



### Systems Policy, Security, and Controls

- *Strategy:* The reliability, availability, and security of HHS's financial systems are of paramount importance. As such, HHS has placed a high-priority on maturing and enhancing its financial systems control environment, strengthening policy, proactively monitoring emerging issues, and ensuring progress toward remediating the Department's IT Material Weakness. HHS is implementing a policy management program to standardize development, implementation, and monitoring of financial systems policies.
- *Progress:* HHS is addressing the Department's IT material weakness by analyzing audit findings, identifying root causes, and implementing solutions collaboratively. The Financial Management Governance Board (FGB) chartered an IT Material Weakness Working Group (MWWG), with members from OpDiv CFO, Chief Information Officer (CIO), and Chief Information Security Officer (CISO) communities. The IT MWWG meets monthly and has developed a roadmap to address pervasive issues, recommend comprehensive remediation approaches, and monitor implementation progress. Working on two fronts – coordinating responsive efforts to address current audit findings, as well as proactive efforts to mature the security and controls environment going forward – HHS initiated projects to address and minimize vulnerabilities and risks related to data and system security, access management, configuration management, and segregation of duties. Supporting these efforts, HHS developed a Financial Systems Policy Development framework, outlining an updated approach to reviewing, refining, and creating financial systems policies and monitoring compliance.

### Governance

- *Strategy:* In November 2013, the Department established the FGB to address enterprise-wide issues, including those related to financial policies and procedures, financial data, and technology. The FGB's goals include establishing HHS financial management governance; providing people, processes, and technology to support governance; engaging stakeholders through effective communication and management strategies; and supporting project alignment with federal mandates and priorities.
- *Progress:* Since its inception, the FGB has met monthly and facilitated executive-level oversight of financial management related areas. It promotes collaboration among stakeholders from the different disciplines within the financial management community by engaging senior leadership from HHS OpDivs and StaffDivs, and across functions such as finance, budget, grants, and IT. The FGB has effectively transformed the way in which financial management initiatives and activities are accomplished in HHS, moving from a Division-specific, vertical focus to a more enterprise-wide approach to solving problems and implementing standards for financial management excellence. This has improved collaboration and strengthened oversight across HHS's financial management and systems environment.

### Program Management

- *Strategy:* To support FSIP and FBIP, HHS established a Department-wide program management framework to facilitate effective implementation of projects and to enhance collaboration across project teams. This includes the Financial Systems Consortium: a body of contractors, federal project managers, and federal contracting officers representing NBS, UFMS, and HIGLAS, that fosters communication and implementation of best practices.
- *Progress:* Department-wide program management and the Financial Systems Consortium played critical roles in coordinating the successful upgrade of the HHS core financial system. Within this framework, project teams were able to share industry best practices, lessons learned, and risks identified during the

## Sharing Opportunities

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## Legal Compliance

### ***Anti-Deficiency Act***

The *Anti-Deficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, or before funds are available, or from accepting voluntary services. As required by the ADA, HHS notifies all appropriate authorities of any ADA violations. ADA reports can be found at [www.gao.gov/legal/anti-deficiency-act/about](http://www.gao.gov/legal/anti-deficiency-act/about).

HHS management is taking necessary steps to prevent future violations. On August 1, 2016, the Director of OMB approved HHS's updated Administrative Control of Funds policy, as required by United States Code, Title 31, *Money and Finance*, Section 1514, "Administrative Division of Apportionments." This policy provides HHS's guidelines to follow in budget execution and to specify basic fund control principles and concepts, including the administrative control of all funds for HHS and its OpDivs, StaffDivs, and Accounting Centers. With respect to two possible issues, we are working through investigations and further assessment where necessary. We remain fully committed to resolving these matters appropriately and complying with all aspects of the law.

### ***Digital Accountability and Transparency Act of 2014***

The *Digital Accountability and Transparency Act of 2014* (DATA Act) expands the *Federal Funding Accountability and Transparency Act of 2006* to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. It directs the federal government to use governmentwide data standards for developing and publishing reports, and to make more information, including award-related data, available on [www.USAspending.gov](http://www.USAspending.gov). Among other goals, the DATA Act aims to improve the quality of the information on [www.USAspending.gov](http://www.USAspending.gov), as verified through regular reviews of the posted data, and to streamline and simplify reporting requirements through clear data standards. Additionally, the DATA Act accelerated the referral of delinquent debt owed to the federal government to the Treasury's Offset Program after 120 days of delinquency.

HHS has played an integral role in the iterative development of data requirements and policy, utilizing internal and governmentwide working groups to analyze and provide feedback to the Treasury. HHS provided feedback on policy guidance through formal OMB policy review periods and by actively participating in various forums such as OMB Office Hours and Open Beta design studios to help shape the evolution of the governmentwide DATA Act implementation and enhance compliance. HHS also collaborated extensively within the Interagency Advisory Committee, which represents the federal communities impacted by the DATA Act, to provide substantive community-specific and cross-cutting feedback to OMB and Treasury in support of governmentwide standardization and related policy considerations.

HHS has revised its DATA Act implementation plan to account for updated requirements from Treasury and additional policy guidance from OMB, as well as the current state of operations and known technical and schedule constraints. HHS implementation is concentrating on reporting mechanisms for May 2017 that minimize changes to existing systems or reporting tools.

To support the initial DATA Act reporting requirements for May 2017, HHS has established file solution teams aligned with the Financial Management, Financial Assistance and Acquisition business lines that will be operationally responsible for generating and validating submissions to ensure transparency, consistency, and compliance. HHS has also established and continued targeted working groups to address specific challenges such as Award ID linkage, Aggregated Data, and Activity Address Code. The DATA Act Program Management Office (DAP) works closely with these file solution teams and working groups to coordinate overall activities and track progress towards meeting key HHS milestone dates. These efforts have enabled HHS to begin compiling data consistent with submission requirements and to iteratively test this data using the most current version of the Treasury broker available on its new DATA Act [www.USAspending.gov](http://www.USAspending.gov) site to support initial compliance with the

## SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROL

DATA Act. Finally, HHS is developing a strategy to leverage existing processes for data validation, error handling, and internal controls in order to effectively identify and address data discrepancies in a timely manner and build the certification process for DATA Act reporting in May 2017.

The DATA Act aims to standardize data and make it more transparent to the public by requiring the federal government to establish governmentwide data standards and publish all federal spending data so that it is accessible, searchable, and reliable. To help meet this goal, the legislation contains Section 5, which calls for a grants Pilot to help inform recommendations to Congress on methods for (1) standardized reporting; (2) elimination of duplication; and (3) reduction of compliance costs.

Since May 2015, HHS has been working in partnership with OMB, as its executing agent for the Grants Section 5 Pilot, to develop and execute pilot test models that focus on finding ways to promote government efficiency and improve the public's experience throughout the grants lifecycle. Test Models include the Common Data Element Repository Library ([www.hhs.gov/about/agencies/asfr/data-act-program-management-office/common-data-element-repository/index.html](http://www.hhs.gov/about/agencies/asfr/data-act-program-management-office/common-data-element-repository/index.html)), Consolidated Federal Financial Reporting ([www.hhs.gov/about/agencies/asfr/data-act-program-management-office/consolidated-federal-financial-reporting/index.html](http://www.hhs.gov/about/agencies/asfr/data-act-program-management-office/consolidated-federal-financial-reporting/index.html)), Single Audit ([www.hhs.gov/about/agencies/asfr/data-act-program-management-office/single-audit/index.html](http://www.hhs.gov/about/agencies/asfr/data-act-program-management-office/single-audit/index.html)), Notice of Award – Proof of Concept ([www.hhs.gov/about/agencies/asfr/data-act-program-management-office/notice-of-award/index.html](http://www.hhs.gov/about/agencies/asfr/data-act-program-management-office/notice-of-award/index.html)), and Learn Grants ([www.hhs.gov/about/agencies/asfr/data-act-program-management-office/learn-grants/index.html](http://www.hhs.gov/about/agencies/asfr/data-act-program-management-office/learn-grants/index.html)). DAP is using these existing tools, forms, and/or processes to collaborate with stakeholders and ascertain if recipient burden may be reduced.

HHS will continue to engage the public in this area through May 2017. The test model results collected by HHS between May 2016 and May 2017 will be reported to OMB for inclusion in the statutorily required report to Congress for legislative action including, but not limited to, consolidating/automating aspects of the federal financial reporting process, simplifying reporting requirements for federal awards, and improving financial transparency.

***Improper Payments Information Act of 2002, Improper Payments Elimination and Recovery Act of 2010, and Improper Payments Elimination and Recovery Improvement Act of 2012***

An improper payment occurs when a payment should not have been made, federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, the recipient uses the funds in an improper manner, or documentation is not available to verify the appropriateness of the payment. The *Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA), requires federal agencies to review their programs and activities to identify programs that may be susceptible to significant improper payments, test high risk programs, and develop and implement corrective action plans for high risk programs. HHS is striving to better detect and prevent improper payments through close review of our programs and activities using sound risk models, statistical estimates, and internal controls.

HHS has shown tremendous leadership in the improper payments arena. HHS has a robust improper payments estimation and reporting process that has been in place for many years, and developed and implemented many corrective actions to prevent and reduce improper payments in our programs. In compliance with the IPIA as amended, HHS completed 35 improper payment risk assessments in FY 2016 (representing risk assessments of programs, employee pay, charge cards, and *Affordable Care Act* Marketplace and related programs), and determined that two programs are high risk and must develop improper payment estimation methodologies. In addition, HHS is publishing improper payment estimates and associated information for 12 high risk programs in this year's AFR, of which six programs reported lower improper payment rates in FY 2016 compared to FY 2015. Lastly, HHS also utilizes the Do Not Pay portal to check payments and awardees to identify potential

improper payments or ineligible recipients. In FY 2016, HHS screened more than \$385 billion in Treasury-disbursed payments through the Do Not Pay portal; HHS identified no improper payments. A detailed report of HHS's improper payment activities and performance is presented in the "Other Information" section of this AFR, under "Improper Payments Information Act Report."

### ***Patient Protection and Affordable Care Act***

The *Affordable Care Act* implements comprehensive health care reform to make quality health care more affordable and accessible. The *Affordable Care Act* includes provisions for a patient's bill of rights, a Health Insurance Marketplace, financial assistance for low and moderate-income Americans to purchase health insurance coverage, incentives for high-quality care from physicians, and expansion of the Medicaid program, helping to provide access to affordable health insurance options for all Americans.

The *Affordable Care Act* also aims to reduce health care fraud, waste and abuse by toughening the sentences for perpetrators of fraud, employing enhanced screening procedures, improving the monitoring of providers, and using predictive modeling technology to target suspect behaviors. These efforts have enabled the government to recover billions of dollars related to improper payments over the last 5 years. For detailed information on improper payment recovery efforts, see the "Program-Specific Reporting Information" section of the "Improper Payments Information Act Report."

A key aspect of the *Affordable Care Act* allows eligible Americans to receive a premium tax credit when purchasing their health insurance coverage through the Health Insurance Marketplace. The amount of the credit can be paid in advance directly to the consumer's health insurer. Consumers then claim the premium tax credit on their federal tax returns, reconciling the credit allowed with any advance payments made throughout the tax year. HHS coordinates closely with the Internal Revenue Service (IRS) on this process.

HHS has implemented many provisions of the *Affordable Care Act*. For more information about implementation of the many *Affordable Care Act* provisions, visit the "Key Features" page at [www.hhs.gov/healthcare/facts-and-features/key-features-of-aca-by-year/index.html](http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca-by-year/index.html).

## **Did you know?**

As of September 2016, 20 million individuals have gained coverage thanks to the *Affordable Care Act*. Today, the uninsured rate is the lowest it has been in history.

### ***Federal Information Technology Acquisition Reform Act***

The *Federal Information Technology Acquisition Reform Act* (FITARA) established an enterprise-wide approach to federal IT investments and provides the Chief Information Officer (CIO) of CFO Act agencies with greater authority over IT investments, including authoritative oversight of IT budgets and budget execution, and IT-related personnel practices and decisions.

Since OMB approved the HHS FITARA Implementation Plan in March 2016, the Agency completed 18 of 39 elements and actions from HHS FITARA Implementation Plan. The CIO reviewed the IT governance policies and procedures for all the OpDivs, published an updated Capital Planning and Investment Control Policy and an addendum to the Enterprise Performance Life Cycle policy, and with the CFO, conducted annual reviews of all IT budgets. In addition, the CIO made progress on the Data Center Optimization Initiative Strategic Plan. FITARA

## SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROL

implementation has strengthened relationships with the OpDivs as well as the CFO, Chief Human Capital Officer, and the Chief Acquisition Officer. These are just a few of the FITARA highlights for FY 2016. Over the next year, the CIO will continue to advance the FITARA goals in HHS.

***Federal Managers' Financial Integrity Act of 1982 and Federal Financial Management Improvement Act of 1996***

The *Federal Managers' Financial Integrity Act of 1982* (FMFIA) requires federal agencies to annually evaluate and assert on the effectiveness and efficiency of their internal control and financial management systems. Agency heads must annually provide a statement on whether there is reasonable assurance that the agency's internal controls are achieving their intended objectives and the agency's financial management systems conform to governmentwide requirements. Section 2 of FMFIA outlines compliance with internal control requirements, while Section 4 dictates conformance with systems requirements. Additionally, agencies must report on any identified material weaknesses and provide a plan and schedule for correcting the weaknesses.

In September 2014, the U.S. Government Accountability Office (GAO) released an updated edition of its *Standards of Internal Control in the Federal Government*, effective FY 2016. The document takes a principles-based approach to internal control, with a balanced focus over operations, reporting, and compliance. In July 2016, OMB released revised Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. The new Circular complements GAO's *Standards*, and it implements requirements of the FMFIA with the intent to improve accountability in federal programs and increase federal agencies' consideration of ERM. The Department with its OpDiv and StaffDiv stakeholders are working together to implement the new requirements.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems to mandated requirements. FFMIA expanded upon FMFIA by requiring that agencies implement and maintain financial management systems that substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the U.S. Standard General Ledger at the transaction level. Guidance for determining compliance with FFMIA is provided in OMB Circular A-123, Appendix D, *Compliance with the FFMIA of 1996*.

HHS is fully focused on the requirements of FMFIA and FFMIA through its internal control program and a Department-wide approach to risk management. Based on thorough ongoing internal assessments and FY 2016 audit findings, HHS provides reasonable assurance that controls are operating effectively. For further information, see the "Management Assurances" section. We are actively engaged with our OpDivs to correct the identified material weaknesses through a corrective action process focused on addressing the true root cause of deficiencies, and supported by active management oversight. More information on the Department's internal control efforts and the HHS Statement of Assurance follows.

## Internal Control

FMFIA requires agency heads to annually evaluate and report on the internal control and financial systems that protect the integrity of federal programs. This evaluation aims to provide reasonable assurance that internal controls are achieving the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives. HHS performs rigorous, risk-based evaluations of its internal controls in compliance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*.

HHS management is directly responsible for establishing and maintaining effective internal controls in their respective areas of responsibility. As part of this responsibility, management regularly evaluates internal control and HHS executive leadership provides annual assurance statements reporting on the effectiveness of controls at meeting objectives. The HHS Risk Management and Financial Oversight Board (RMFOB) evaluates the OpDivs' management assurances and recommends a Department assurance for the Secretary's consideration and approval, resulting in the Secretary's annual Statement of Assurance.

HHS aims to strengthen its internal control assessment and reporting process to more effectively identify key risks, develop effective risk responses, and implement timely corrective actions. The HHS FY 2016 OMB Circular A-123 assessment and the financial statement audit reported one material weakness in Information System Controls and Security. Additionally, HHS recognizes one material noncompliance with IPIA regarding Error Rate Measurement and one material noncompliance with the *Social Security Act* related to the Medicare appeals process.

Maintaining integrity and accountability in all programs and operations is critical to HHS's mission and demonstrates responsible stewardship over assets and resources. It also promotes responsible leadership, ensures the effective delivery of high quality services to the American people, and maximizes desired program outcomes.



President Obama designated HHS as the lead federal agency responsible for coordinating the Administration's response and recovery efforts in Flint, Michigan.



## MANAGEMENT ASSURANCES

### Statement of Assurance



#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary  
Washington, DC 20201

The Department of Health and Human Services' (HHS or the Department) management is responsible for managing risks and maintaining effective internal control to meet the objectives of Sections 2 and 4 of the *Federal Managers' Financial Integrity Act of 1982* (FMFIA). These objectives are to ensure (1) effective and efficient operations; (2) reliable financial reporting; and (3) compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives.

HHS conducted its assessment of risk and internal control in accordance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. Based on the results of the assessment, the Department provides reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2016, with the exception of one material weakness related to Information System Controls and Security, and two material noncompliances: one involving noncompliance with the *Improper Payments Information Act* (IPIA) related to Error Rate Measurement, and the second involving noncompliance with the *Social Security Act* related to the Medicare appeals process.

HHS is taking steps to address the material weakness related to Information System Controls and Security and the material noncompliance related to the Medicare appeals process, as described in the "Corrective Action Plans for Material Weaknesses" section. Remediation for the material noncompliance related to Error Rate Measurement relies on a modification to legislation to require states to participate in an improper payment rate measurement.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires agencies to implement and maintain financial management systems that substantially comply with federal financial management system requirements, federal accounting standards, and the United States Standard General Ledger (USSGL) at the transaction level. HHS conducted its evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. Based on the results of this assessment, HHS provides reasonable assurance that its overall financial management systems substantially comply with the FFMIA and substantially conform to the objectives of FMFIA, Section 4.

HHS will continue to ensure accountability and transparency over the management of taxpayer dollars, and strive for the continuing progress and enhancement of its internal control and financial management programs.

/Sylvia M. Burwell/

Sylvia M. Burwell  
Secretary  
November 14, 2016



## Summary of Material Weaknesses

### 1. Information System Controls and Security

HHS acknowledges a material weakness related to Information System Controls and Security. This material weakness includes general and application controls weaknesses specifically related to segregation of duties, access controls, and configuration management, as well as other information system security weaknesses that were identified through the annual Chief Financial Officer (CFO) Audit (*Federal Information Systems Control Audit Manual*), annual *Federal Information Security Management Act* (FISMA) assessment, and other internal management reviews. While no single financial management system had a material weakness, the nature of the deficiencies throughout the Department leads management to conclude that these aggregate deficiencies warrant classification as a material weakness under Section 2 of FMFIA.

### 2. Error Rate Measurement

HHS reports a statutory limitation relating to the Temporary Assistance for Needy Families (TANF) program that results in a material noncompliance with IPIA. The TANF program is not reporting an error rate for FY 2016, as required by IPIA, because statutory limitations currently prohibit HHS from requiring states to provide information needed for determining a TANF improper payment measurement.

### 3. Medicare Appeals Process

Several factors, including the growth in Medicare claims and HHS's continued investment and focus on ensuring program integrity, have led to more appeals than Levels 3 and 4 of the Medicare appeals process can adjudicate within the timeframes required by the *Social Security Act*.

From FY 2010 through FY 2015, the HHS Office of Medicare Hearings and Appeals (OMHA) experienced an overall 442 percent increase in the number of Level 3 appeals received annually. During the same timeframe, the HHS Departmental Appeals Board (DAB) experienced an overall 267 percent increase in the number of Level 4 appeals it received annually. However, while the volume of appeals has increased dramatically, funding has remained comparatively stagnant for the relevant OMHA and DAB operations. As a result, at the end of FY 2016, 658,307 appeals were waiting to be adjudicated by OMHA and 22,707 appeals were waiting to be reviewed at the DAB Medicare Appeals Council. This has led to the inability to meet statutory decisional timeframes of 90 days at Levels 3 and 4 of the Medicare appeals process.

Under current resources (and without any additional appeals), it would take several years for both OMHA and the DAB Medicare Appeals Council to process their respective backlogs.

## MANAGEMENT ASSURANCES

**Corrective Action Plans for Material Weaknesses****1. Information System Controls and Security**

HHS has placed a high priority on maturing its financial systems controls environment and remediating the Information System Controls and Security material weakness through strengthening policy management, proactively monitoring emerging issues, and ensuring progress toward correcting deficiencies contributing to the material weakness. A Department-wide IT Material Weakness Working Group (MWWG) was established in FY 2015 with members from the CFO, Chief Information Officer, and Chief Information Security Officer Communities to collaboratively identify challenges, conduct root cause analyses, and jointly implement comprehensive solutions. The IT MWWG developed a roadmap to proactively improve the financial systems in the areas of segregation of duties, access controls, configuration management, and FISMA weaknesses that contribute to the Information System Controls and Security material weakness. In FY 2016, HHS has:

- Analyzed FY 2014 and FY 2015 IT audit results to understand the factors contributing to the Information System Controls and Security material weakness;
- Evaluated Federal Information System Controls Audit Manual (FISCAM) system controls gaps based on evaluation criteria derived from National Institute of Standards and Technology (NIST) standards and HHS policies;
- Identified cross-cutting issues and developed preliminary recommendations to address Department-wide and system level challenges; and
- Developed a Financial Systems Policy Management framework, outlining an updated approach to creating, implementing, and monitoring financial systems policies. Further, a pilot program to monitor policy compliance for a core accounting system was established with plans to roll out the program more broadly across the financial systems environment.

In addition to proactive efforts, HHS has made significant progress in remediating audit findings as part of the responsive efforts to address the Information System Controls and Security material weakness.

In the first quarter of FY 2016, HHS completed its major financial management systems upgrade and transitioned the hosting services for key financial systems to a Cloud Service Environment certified by the Federal Risk and Authorization Management Program (FedRAMP), enhancing systems security, scalability, reliability, and availability.

In FY 2017, HHS will continue its collaborative efforts to identify high risk areas within the HHS financial systems environment, develop and implement comprehensive solutions to address department-wide and system level controls gaps in the areas of policy, business application and infrastructure, and monitor corrective action implementation to meet the Department's objectives. HHS will continue to report remediation progress to the Risk Management and Financial Oversight Board and maintain accountability and commitment to strengthen the HHS financial systems environment.

**2. Error Rate Measurement**

Current statutory limitations restrict corrective actions HHS can take to develop an error rate for TANF. HHS plans to encourage Congress to consider statutory modifications that would allow for greater accountability, including a reliable error rate measurement if appropriate when legislation is considered to reauthorize TANF.

### 3. Medicare Appeals Process

HHS has a three-pronged strategy to improve the Medicare appeals process:

- 1) Invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog;
- 2) Take administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process; and
- 3) Propose legislative reforms that provide additional funding and new authorities to address the appeals volume.

The *FY 2017 President's Budget* request includes a comprehensive legislative package aimed at both helping the Department process a greater number of appeals and reducing the number of appeals that reach OMHA. Accounting for current administrative actions and the enactment of proposed funding increases and legislative actions outlined in the *FY 2017 President's Budget*, HHS projects that the backlog could potentially be reduced to 240,810 appeals by the end of FY 2018 and may be eliminated by FY 2019.

## LOOKING AHEAD TO 2017

HHS is the U.S. government's principal agency for protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including vulnerable populations. Our OpDivs and StaffDivs strive each day to help more Americans acquire affordable health care, to protect and enhance the health of the people of this country and the world, and to assist those who are least able to help themselves. These daily achievements support the Department's existing strategic goals and objectives. In 2017, HHS will update its Strategic Plan to align with the priorities of the next Presidential Administration.

### Strengthen Health Care

HHS is responsible for implementing many of the provisions of the *Affordable Care Act*, which makes health insurance coverage more secure and reliable for Americans, makes coverage more affordable and accessible for families and small business owners, and helps bring down health care costs. The *Affordable Care Act* also expands consumer choice, supports informed decision making and increases health insurance coverage for low-income populations, partly through the expansion of Medicaid eligibility and the advent of the Health Insurance Marketplace.

### Advance Scientific Knowledge and Innovation

HHS is working to advance scientific knowledge and innovation to prevent, diagnose, and treat diseases and disorders, as well as address emerging health threats, and sustain a vital and cutting edge workforce and scientific infrastructure. Medical breakthroughs, fueled by scientific discovery, have made the difference between life and death for countless Americans. Nevertheless, the need for better health interventions remains. Continuing to improve the health and well-being of Americans requires ongoing investments, with goals that range from improving our understanding of fundamental biological processes to identifying the best modes of prevention and treatment. HHS investments have improved the health of many Americans, but the path from basic discovery into safe, effective patient care can be long.

### Advance the Health, Safety, and Well-Being of the American People

HHS focuses on creating environments that promote healthy behaviors to prevent chronic disease and health conditions, including those related to tobacco use and substance abuse, being overweight or obese, and mental disorders. These conditions result in the most deaths, disability, and substantial human and fiscal costs for Americans. HHS works to promote prevention and wellness across its programs and with a variety of partner stakeholders.

HHS partners with state, local, tribal, urban Indian, and other service providers to sustain an essential safety net of services that protect children and youth, promote their resilience in the face of adversity, and ensure their healthy development from birth through the transition to adulthood. Health and early intervention services ensure children get off to a good start from infancy. Early childhood programs, including Head Start, enhance the school readiness of preschool children. Child welfare programs, including child abuse prevention, foster care, and adoption assistance, target those families in which there are safety or neglect concerns. Services for children exposed to trauma or challenged with mental or substance use disorders provide support for those with behavioral health care needs. Several HHS programs also promote positive youth development and seek to prevent risky behaviors in youth.

Promoting economic and social well-being requires attention to a complex set of factors, through the collaborative efforts of agencies, policymakers, researchers, community members, and providers. HHS OpDivs work together and collaborate across departments to maximize the potential benefits of various programs, services, and policies designed to improve the well-being of individuals, families, and communities.

Over the past decade, our nation has renewed its efforts to address large-scale incidents that have threatened human health, such as natural disasters, disease outbreaks, and terrorism. Working with its federal, state, local, tribal, and international partners, as well as industry in public-private partnerships, HHS has improved and exercised response capabilities and developed medical countermeasures.

### Did you know?

Injuries are the leading cause of death among American Indians and Alaska Natives ages 1 to 44. The IHS Injury Prevention Program aims to decrease the incidence of injuries and increase the ability of tribes to prevent injuries within their communities.

## Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

Stewardship of federal funds involves more than ensuring that resources are allocated and expended responsibly. Managing federal health care related investments with integrity and vigilance will safeguard taxpayer dollars as well as benefit the public through improved health and enhanced well-being. Responsible stewardship involves allocating these resources effectively—and for activities that generate the highest benefits. HHS has placed a strong emphasis on protecting program integrity and the well-being of program beneficiaries by identifying opportunities to improve program efficiency and effectiveness. HHS is making every effort to ensure that the right recipient is receiving the right payment for the right reason at the right time.

HHS is strongly committed to data security and the protection of personal privacy and confidentiality as a fundamental principle governing the collection and use of data. HHS protects the confidentiality of individually identifiable information in all public data releases, including publication of datasets on the Web. By employing state-of-the-art processes for data prioritization, release, and monitoring, HHS increases the value derived from information in several ways. Consumers are able to access information and benefit directly from using it personally. Public administrators can use these information resources to enhance service delivery and improve customer satisfaction.

As we near the end of this Administration, HHS leadership is committed to leaving the Department in a strong position to continue its vital work. To do this, HHS will stay committed to developing effective systems, workforce, and infrastructure that can address complicated and emerging challenges. These efforts will allow HHS to continue toward its goal of improved health and well-being among Americans.

## FINANCIAL SUMMARY AND HIGHLIGHTS

Once again, HHS received an unmodified audit opinion on its financial statements and notes<sup>1</sup> for the year ending September 30, 2016. We present these in the “Financial Section” of this report. At HHS, we take pride in the preparation of our financial statements, yet it can sometimes be difficult to draw the relationships between the information in the statements and the overall performance of an agency. This section is presented as an interpretation of the financial statements, which include the Consolidated Balance Sheets, Consolidated Statement of Net Cost, Consolidated Statement of Changes in Net Position, Combined Statement of Budgetary Resources, Statement of Social Insurance, and the Statement of Changes in Social Insurance Amounts, as well as selected Notes to the Principal Financial Statements. Included in this analysis is a year-over-year summary of key financial balances, nature of significant changes, and highlights of key financial events to assist our readers in establishing the relevance of the financial statements to the operations of HHS.

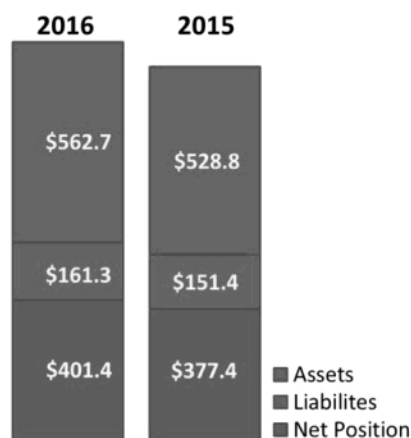
As a federal entity, HHS's financial position and activities are significant to the governmentwide statements. Based on the FY 2015 *Financial Report of the United States Government*, our net operating cost was larger than any single agency across the entire federal government<sup>2</sup>. A similar relationship exists within HHS, where the Department is significantly represented by one OpDiv. CMS alone consistently stewards the largest share of our resources. Therefore, noteworthy changes in HHS balances are primarily related to fluctuations in CMS program activity.

### Balance Sheets

To communicate performance for HHS at fiscal year-end, the Consolidated Balance Sheets show the resources available to HHS (Assets) and claims against those assets (Liabilities). The remainder represents the equity retained by the government (Net Position). The table below summarizes the major components of the FY 2016 and FY 2015 year-end balances of HHS's assets available for use, the liabilities owed by HHS, and the equity retained by HHS as represented by the Net Position.

Financial Condition Summary		Change (2016-15)			
(in Billions)	2016	2015	\$	%	
Fund Balance with Treasury	\$ 237.8	\$ 219.5	\$ 18.3	8%	
Investments, Net	262.1	269.7	(7.6)	(3)%	
Accounts Receivable	25.2	22.9	2.3	10%	
Other Assets	37.6	16.7	20.9	125%	
<b>Total Assets</b>	<b>\$ 562.7</b>	<b>\$ 528.8</b>	<b>\$ 33.9</b>	<b>6%</b>	
Accounts Payable	\$ 1.3	\$ 0.9	\$ 0.4	44%	
Entitlement Benefits Due and Payable	108.2	108.1	0.1	0%*	
Accrued Liabilities	14.4	14.3	0.1	1%	
Federal Employee and Veterans' Benefits	12.9	12.1	0.8	7%	
Other Liabilities	24.5	16.0	8.5	53%	
<b>Total Liabilities</b>	<b>\$ 161.3</b>	<b>\$ 151.4</b>	<b>\$ 9.9</b>	<b>7%</b>	
<b>Net Position</b>	<b>\$ 401.4</b>	<b>\$ 377.4</b>	<b>\$ 24.0</b>	<b>6%</b>	
<b>Total Liabilities &amp; Net Position</b>	<b>\$ 562.7</b>	<b>\$ 528.8</b>	<b>\$ 33.9</b>	<b>6%</b>	

\*Change is less than one percent



<sup>1</sup> Due to the uncertainty of the long-range assumptions used in the Statement of Social Insurance model, our auditors were not able to express an opinion on the Statement of Social Insurance and the Statement of Social Insurance Amounts and associated footnotes.

<sup>2</sup> HHS's net costs are 27 percent of the federal government's total costs; the Social Security Administration costs are 24 percent, Department of Defense are 15 percent, Treasury's Interest on Treasury Security Held by the Public are 6 percent, and the Department of Veterans Affairs are 4 percent. All remaining agencies combined only represent 24 percent.

Source: FY 2015 Financial Report of the United States Government [fiscal.treasury.gov/fsreports/rpt/finrep/fr/fr\\_index.html](https://www.fiscal.treasury.gov/fsreports/rpt/finrep/fr/fr_index.html)

Assets

The total Assets for HHS were \$562.7 billion at year-end, representing the value of what we own and manage. This is an increase of 6 percent or approximately \$33.9 billion over September 30, 2015.

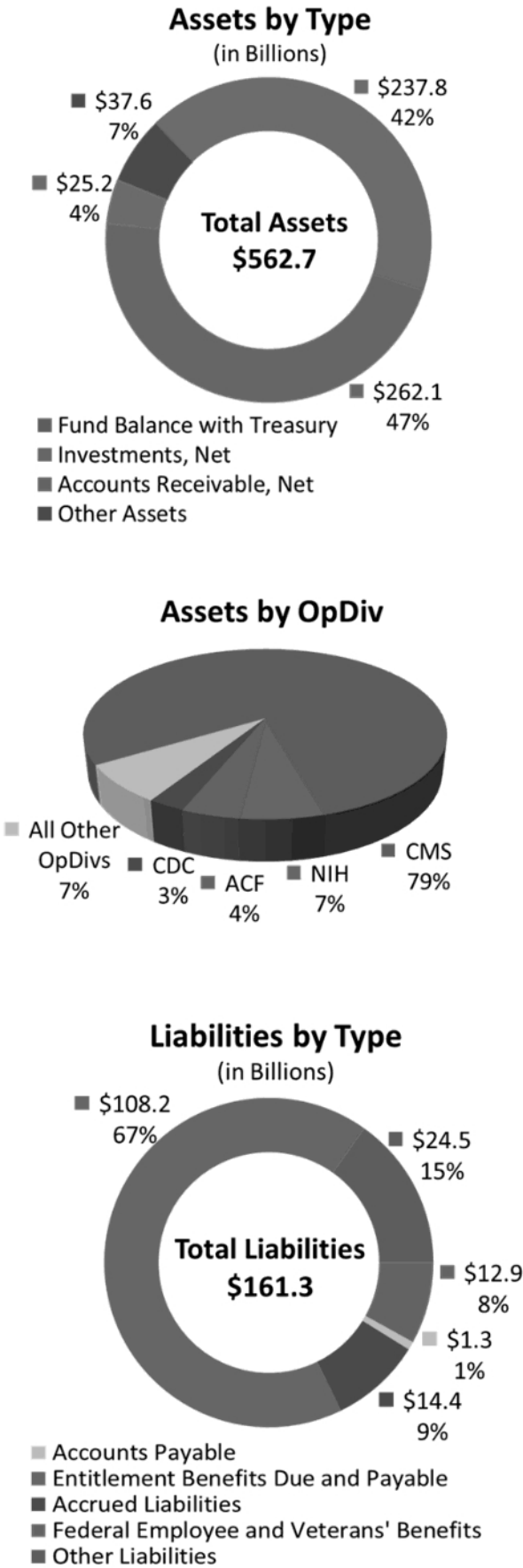
The Other Assets line contains the largest net change between FY 2016 and FY 2015 at \$20.9 billion. This is primarily represented by a \$21.5 billion increase in advances, including a \$14.6 billion increase for the Supplemental Medical Insurance (SMI) Prescription Drug and Medicare Advantage Benefits advances and a \$6.9 billion increase in Medicare Hospital Insurance (HI) advances.

Net Investments and the Fund Balance with Treasury (FBwT) together comprise 89 percent of our total assets, which is a 4 percent decrease from 93 percent in FY 2015. Of the \$18.3 billion FBwT increase, 63 percent was within CMS. The CMS increase includes FBwT increases for SMI of \$8.3 billion and for the Children’s Health Insurance Program (CHIP) of \$5.6 billion, offset by FBwT decreases in other CMS programs.

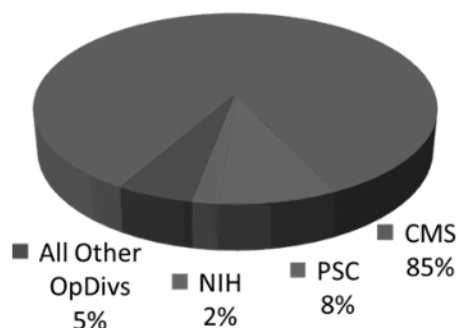
The chart to the right, “Assets by OpDiv,” demonstrates asset distribution within the Department. The OpDiv asset balances ranged from \$323.0 million at AHRQ to \$445.7 billion at CMS. ACF had one of the largest percentile and dollar value asset increases (at 8 percent and \$1.8 billion) over FY 2015 due to an expansion of the Temporary Assistance for Needy Families (TANF) program of \$1.1 billion and additional resources provided to Head Start of \$0.5 billion.

Liabilities

Our Liabilities, or amounts that we owe from past transactions or events, were \$161.3 billion on September 30, 2016. This represents an increase of \$9.9 billion, or 7 percent more than the FY 2015 liabilities. The driving factor behind this increase can be found in the Other Liabilities line, which increased 53 percent (\$8.5 billion) over FY 2015. A major contributor to this change is the result of the *Bipartisan Budget Act of 2015 (Section 601)* which authorized a transfer from the General Fund to SMI. The mandatory repayment of the General Fund transfer created the increased liability. *Section 601* also created an additional premium, which will be charged together with the regular Medicare Part B monthly premiums and will be used to pay back the General Fund without interest.



## FINANCIAL SUMMARY AND HIGHLIGHTS

**Liabilities by OpDiv**

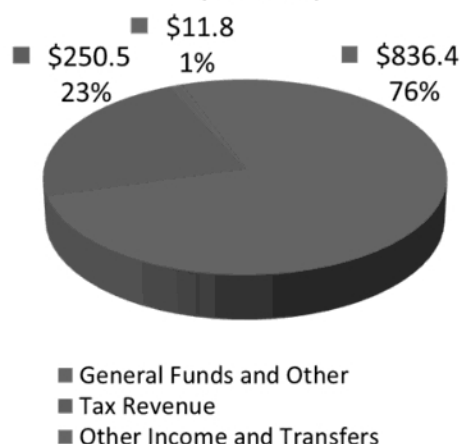
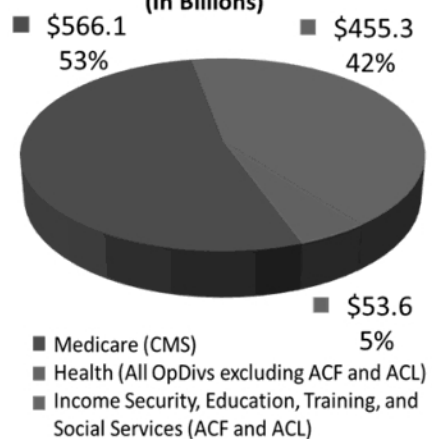
The OpDivs with the largest and smallest asset balances are also the OpDivs with the largest and smallest liabilities. With the majority share, CMS reports \$136.9 billion and 85 percent of the HHS liabilities, while AHRQ (shown in All Other OpDivs on the chart to the left) has liabilities around \$25.0 million. Other than CMS, PSC had the largest OpDiv dollar value increase in liabilities over FY 2015 of \$959.2 million. Of this PSC increase, \$819.0 million is an increase to the Pension Liability to capture updated estimates based on mid-year and year-end reviews of their Pension Liability.

**Statement of Changes in Net Position**

The Consolidated Statement of Changes in Net Position displays the activities affecting the difference between the beginning net position and ending net position, as shown on our Consolidated Balance Sheets. This is also represented as the difference between assets and liabilities.

Changes in assets are shown by breaking out where HHS gets the money from, known as our financing sources. Total financing sources includes both the Total Financing Sources and Total Budgetary Sources lines from the Statement of Changes in Net Position.

We receive the majority of our funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. HHS's largest financing source, our General Funds and Other, increased over FY 2015 by 5 percent (\$39.0 billion) from \$797.4 billion to \$836.4 billion. Fluctuations in tax revenue collected are due to legislative changes. The increase in tax revenue of 5 percent is comparable to the prior year 4 percent increase in tax revenue.

**HHS Gets the Money From...**  
(In Billions)**HHS Used the Money For...**  
(In Billions)**Statement of Net Cost**

The Consolidated Statement of Net Cost represents how we spent the money. This can also be stated as the difference between the costs incurred by our programs less associated revenues. Our Net Cost of Operations for the year ended September 30, 2016, totaled approximately \$1.1 trillion. The chart on the left shows consolidating HHS costs by Major Budget Function<sup>3</sup>, which are the categories displayed in the federal budget. Most agencies have one or two budget functions, where HHS has many.

<sup>3</sup> Totals in the chart are exclusive of Intra-HHS Eliminations from the Consolidating Statement of Net Cost by Budget Function.



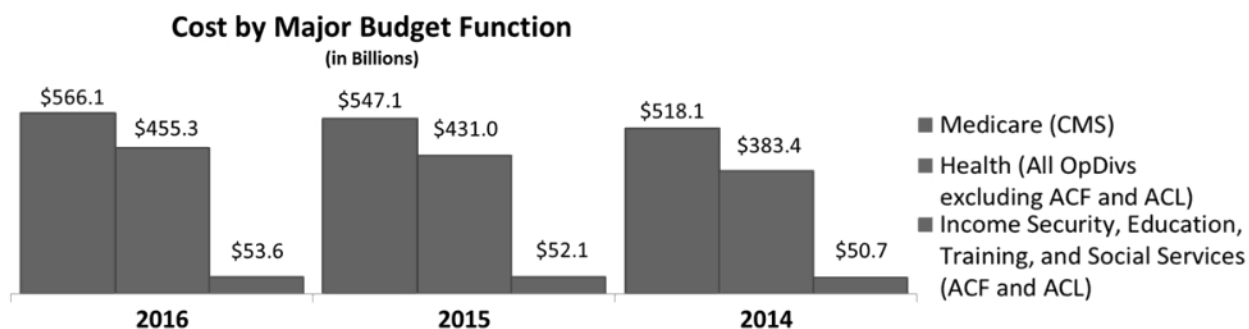
## FINANCIAL SUMMARY AND HIGHLIGHTS

The table below presents our FY 2016 Consolidated Net Cost of Operations, which we break out into Responsibility Segments between CMS and the remaining OpDivs (Other Segments). Net cost for CMS increased by \$39.4 billion between FY 2016 and FY 2015. The majority of this increase relates to benefit expenses reflecting an expansion of Medicaid (with increases of costs approximately totaling \$13.9 billion), as well as benefit expense increases for the Medicare SMI of \$12.2 billion, and increases of \$7.4 billion for Medicare Part D. There was a nominal increase in total Net Cost of Operations for the remaining HHS segments at around \$5.4 billion.

Net Cost of Operations			Change (2016-15)	
(in Billions)	2016	2015	\$	%
<b>Responsibility Segments:</b>				
CMS Gross Cost	\$ 1,044.6	\$ 1,011.3	\$ 33.3	3%
CMS Exchange Revenue	(91.9)	(98.0)	6.1	(6)%
CMS Net Cost of Operations	\$ 952.7	\$ 913.3	\$ 39.4	4%
<b>Other Segments:</b>				
Other Segments Gross Cost	\$ 127.2	\$ 120.7	\$ 6.5	5%
Other Segments Exchange Revenue	(5.1)	(4.0)	(1.1)	28%
Other Segments Net Cost of Operations	\$ 122.1	\$ 116.7	\$ 5.4	5%
<b>Net Cost of Operations</b>	<b>\$ 1,074.8</b>	<b>\$ 1,030.0</b>	<b>\$ 44.8</b>	<b>4%</b>

Rounding in CMS Exchange Revenue

As stated previously, HHS classifies costs by Major Budget Function such as Medicare, Health, Income Security, and Education. This is shown on the Consolidating Statement of Net Cost by Budget Function in the "Other Information" section of this report. Below are the three-year cost trends for these Major Budget Functions<sup>4</sup>. Total net costs for Medicare \$566.1 billion and Health \$455.3 billion Budget Functions account for 95 percent of our annual net costs.

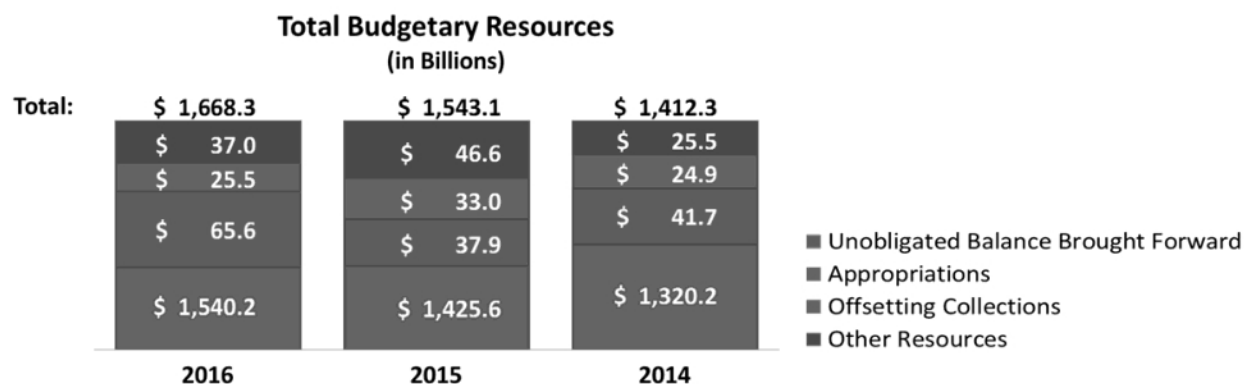


### Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout 2016 and 2015, and the status of those resources at the fiscal year-end. The primary components of our resources, totaling approximately \$1.7 trillion for FY 2016, are appropriations from Congress, resources not yet used from previous years (unobligated balances brought forward), spending authority from offsetting collections, and other budgetary resources. This represents an increase of \$125.2 billion, or 8 percent, over FY 2015. The following chart highlights trends in these balances over the past three fiscal years.

<sup>4</sup> Totals in the chart are exclusive of Intra-HHS Eliminations from the Consolidating Statement of Net Cost by Budget Function.

## FINANCIAL SUMMARY AND HIGHLIGHTS



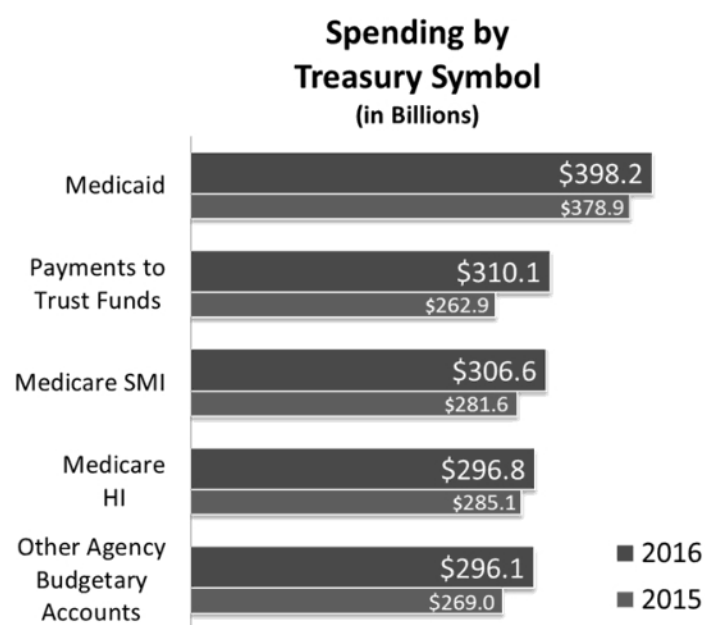
The increase in appropriations are primarily related to increases in the Payments to Trust Funds of \$44.6 billion, Medicare SMI of \$43.6 billion, Medicare HI of \$11.8 billion, Medicaid of \$11.2 billion, and CHIP of \$1.7 billion. For further details, see the Combining Statement of Budgetary Resources in the “Financial Section” of this report.

### Schedule of Spending

HHS has elected to present our trends in spending in the audited Notes to the Principal Financial Statements titled, Combined Schedule of Spending. The chart below illustrates this spending as of September 30, 2016 and 2015 for the top four Treasury Account Symbols (TAS). The remaining TAS are presented in Other Agency Budgetary Accounts.

The New Obligations and Upward Adjustments line on the Combined Statement of Budgetary Resources is the same as Total Amounts Agreed to be Spent line on the Combined Schedule of Spending. Total obligations for FY 2016 were approximately \$1.6 trillion, a 9 percent increase over the approximately \$1.5 trillion in obligations for FY 2015.

The Department’s total spending is once again significantly represented by four of CMS’s TAS; Medicaid, Medicare HI, Medicare SMI, and Payments to Trust Funds; at 82 percent of HHS total obligations.



As the American public will soon be able to see more clearly on the new [USAspending.gov](http://USAspending.gov) website<sup>5</sup>, the majority (47 percent) of all HHS spending was made through Grants, Subsidies, and Contributions at \$749.2 billion. We are the largest grant-making agency in the federal government. Additionally, HHS has incurred obligations for Federal Assistance Direct Payments (44 percent) totaling \$704.0 billion. We classify obligations by items or services provided into categories known as object classes. For more information on object classes, see the Combined Schedule of Spending by Object Class in the “Other Information” section of this report.

<sup>5</sup> The goal date for go-live DATA Act reporting is May 2017.

## Statement of Social Insurance

The Statement of Social Insurance presents the 75-year actuarial present value of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise for current and future program participants. This projection is considered to be important information regarding the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheets, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

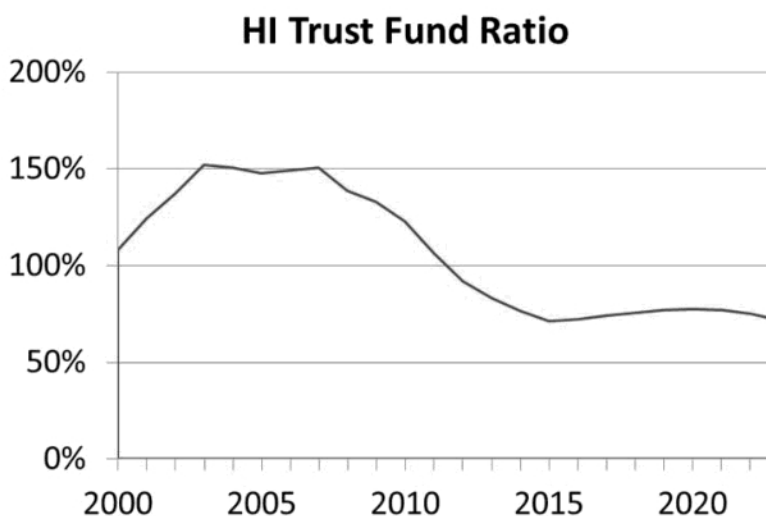
Actuarial present values are computed under the intermediate set of assumptions specified in the *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

The Statement of Social Insurance presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, *plus* the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, *plus* the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from \$(3.2) trillion, determined as of January 1, 2015, to \$(3.8) trillion, determined as of January 1, 2016.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2016,

of future cash flow for all current and future participants to \$(3.6) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is \$(10.2) trillion.



## HI TRUST FUND SOLVENCY

### Pay-as-you-go Financing

The HI Trust Fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI Trust Fund assets have been declining. The following table shows that HI Trust Fund assets<sup>6</sup>, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio has steadily dropped from 95 percent at the beginning of FY 2012 to 67 percent at the beginning of FY 2016.

Trust Fund Ratio Beginning of Fiscal Year					
	2016	2015	2014	2013	2012
HI	67%	73%	77%	86%	95%

### Short-Term Financing

The HI Trust Fund is deemed adequately financed for the short term when actuarial estimates of trust fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2016 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2016 Trustees Report, the HI Trust Fund ratio is estimated to continue decreasing through 2025 and remain at approximately 70 percent through 2022. From the end of 2015 to the end of 2020, assets are expected to increase, from \$193.8 billion to \$216.6 billion, but then decrease to \$137.7 billion by the end of 2025.

### Long-Term Financing

The short-range outlook for the HI Trust Fund has worsened as compared to what was projected last year. After 2020, the trust fund ratio starts to decline quickly until the fund is depleted in 2028, two years earlier than projected last year. HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected. Program cost is expected to exceed total income in all years. When the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 87 percent in 2028 to 79 percent in 2040 and then to increase to about 86 percent by the end of the projection period.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of beneficiaries eligible for benefits drops from 3.1 in 2015 to about 2.1 by 2090. In addition, health care costs continue to

### Did you know?

Only four federal benefit programs meet the criteria to report a Statement of Social Insurance. They are the Medicare, Social Security, Railroad Retirement, and Black Lung programs.



<sup>6</sup> Assets at the beginning of the year to expenditures during the year.

rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is \$3.6 trillion, which is 0.7 percent of taxable payroll and 0.3 percent of Gross Domestic Product (GDP) over the same period.

Significant uncertainty surrounds the estimates for the Statement of Social Insurance. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term

## Did you know?

Based on the latest 2016 projections, Medicare and Medicaid (including state funding) represent 38 cents of every dollar spent on health care in the U.S.—or looking at it from three other perspectives: 54 cents of every dollar spent on nursing homes, 44 cents of every dollar received by U.S. hospitals, and 34 cents of every dollar spent on physician services.



and ultimate assumptions used in the projections. For more information, please refer to the *Required Supplementary Information: Social Insurance* disclosures required by the Federal Accounting Standards Advisory Board.

## SMI TRUST FUND SOLVENCY

The SMI Trust Fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI Trust Fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D

account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, the appropriation for Part D general revenues has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account five business days before the benefit payments to the plans. This transfer occurred again in February 2016 and is expected to occur consistently thereafter. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect the new policy.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is \$0. However, from a government wide perspective, general fund transfers as well as interest payments to the Medicare Trust Funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is \$(28.6) trillion.

Even though from a program perspective, the unfunded liability is \$0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2015, SMI expenditures were 2.1 percent of GDP. By 2090, SMI expenditures are projected to grow to 3.8 percent of the GDP.

The following table<sup>7</sup> presents key amounts from our basic financial statements for fiscal year 2014 through 2016.

**Table of Key Measures**

<b>Financial Condition Summary (in Billions)</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>
<b>Net Position (end of fiscal year)</b>			
Assets	\$ 446.0	\$ 418.6	\$ 380.0
Less Total Liabilities	137.3	129.1	104.7
Net Position (assets net of liabilities)	\$ 308.7	\$ 289.5	\$ 275.3
<b>Change in Net Position (end of fiscal year)</b>			
Net Costs	\$ 953.1	\$ 913.8	\$ 837.8
Total Financing Sources	960.1	910.3	820.4
Change in Net Position	\$ 7.0	\$ (3.5)	\$ (17.4)
<b>Statement of Social Insurance (calendar year basis)</b>			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	\$(3,821.7)	\$(3,187.0)	\$(3,822.9)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	\$(3,187.0)	\$(3,822.9)	\$(4,771.8)
Change in Present Value	\$ (634.7)	\$ 635.9	\$ 948.9

### Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2016, decreased by \$168.6 billion due to advancing the valuation date by one year and including the additional year 2090, by \$288.7 billion due to changes in the projection base, and by \$366.1 billion due to the changes in economic and health care assumptions. However, changes in demographic assumptions and legislation changes increased the present value of future cash flows by \$182.4 billion and \$6.4 billion, respectively.

<sup>7</sup> The table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, the CMS presents the closed group measure and open group measure.

## Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) Number 17, Accounting for Social Insurance (as amended by *SFFAS Number 37, Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), HHS has included information about the Medicare trust funds – HI and SMI. The Required Supplementary Information (RSI) presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds.

## Limitation of the Principal Financial Statements

The principal financial statements in the “Financial Section” have been prepared to report our financial position and results of operations, pursuant to the requirements of 31 U.S.C. §3515(b). Although the statements have been prepared from our books and records in accordance with generally accepted accounting principles for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing HHS with resources and budget authority.

A black and white photograph of a man and a woman in a greenhouse. The man, on the left, has a beard and glasses, wears a plaid shirt and an apron, and holds a small potted plant. The woman, on the right, has long dark hair and wears a cable-knit sweater, also holding a small potted plant. They are both smiling and looking at each other. In the background, there are rows of plants in trays and a shopping cart filled with plants on the right.

## Financial Section

# 2

### In This Section

- Message from the Chief Financial Officer
- Report of the Independent Auditors
- Department's Response to the Report of the Independent Auditors
- Principal Financial Statements
- Notes to the Principal Financial Statements
- Required Supplementary Stewardship Information
- Required Supplementary Information



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## MESSAGE FROM THE CHIEF FINANCIAL OFFICER



I am pleased to join the Secretary in presenting the Department of Health and Human Services' (HHS) Fiscal Year (FY) 2016 Agency Financial Report. HHS oversees one of the largest budgets in the world, managing one of every four dollars spent by the federal government. Serving as effective stewards of public funds is an integral component of achieving our mission.

This year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors identified one material weakness and two significant deficiencies. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the

Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2016 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board.

During FY 2016, HHS continued to make progress in executing its multi-year financial systems modernization initiative to strengthen system security, reliability, and availability, as well as target remediation of the Department's material weakness pertaining to information technology (IT). Our efforts included:

- Completing the major upgrade of our core financial system in December 2015 – on-time, on-budget, and fully functional – enabling HHS to mitigate mission risk, improve functionality and performance, and strengthen overall system controls and security.
- Transitioning key financial systems to a Federal Risk and Authorization Management Program certified cloud service provider, supporting governmentwide IT priorities and further enhancing system security, reliability, availability, performance, and scalability.
- Maturing the overall financial systems security and controls environment, including strengthening policy development and monitoring; proactively monitoring emerging issues; and coordinating a Department-wide initiative to systematically address HHS's IT material weakness by defining the complete problems, identifying root causes, and implementing collaborative solutions.

We also made significant progress in remediating significant deficiencies related to Financial Reporting Systems, Analyses, and Oversight; and the Financial Management Close and Review Process. Our remediation efforts included:

- Continuing to review, update, and develop HHS policies in financial management, grants, and acquisitions to ensure compliance with applicable federal regulations and guidance.
- Establishing a mature and structured corrective action planning process, consisting of increased Operating Division (OpDiv) communication and support through a standardized approach, policy, guidance, training, and on-site technical assistance.

HHS also achieved significant accomplishments in several additional areas that strengthen Department management:

- Continued implementation of Enterprise Risk Management across the Department and in its OpDivs, consistent with the July 2016 release of OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*.
- Established a strategy, cross-functional governance structure, and implementation teams to support the *Digital Accountability and Transparency Act* reporting requirements by May 2017.
- Expanded HHS's business intelligence and analytics capabilities through the Financial Business Intelligence System – enhancing access to financial management information, supporting internal and external reporting requirements, and facilitating effective stewardship and decision making.
- Continued to improve governance through the Financial Management Governance Board, allowing HHS to effectively address enterprise-wide financial management issues related to policies, data, and technology, and enhance collaboration across the Department's financial management community.

Our Chief Financial Officer (CFO) community is dedicated to working together to improve Department-wide operations, financial reporting and systems, while focusing our efforts on strengthening internal control, maintaining data integrity, increasing data transparency, and reporting reliable information to support effective internal and external decision making.

The Association of Government Accountants presented HHS with the *Certificate of Excellence in Accountability Reporting* award for our FY 2015 AFR, the third consecutive year we earned recognition for our financial report. The award is given to federal agencies following a rigorous, independent review against a comprehensive set of standards. We were also presented with a Best in Class award for our Improper Payments and Elimination Act Reporting Detail.

The achievements depicted in this report are a reflection of the earnest effort and diligent dedication of our employees and partners who collaborate throughout the year to serve our mission and the American people. We will continue to conscientiously serve our stakeholders in an accountable and transparent manner.

/Ellen G. Murray/

Ellen G. Murray  
Assistant Secretary for Financial Resources and  
Chief Financial Officer  
November 14, 2016

## REPORT OF THE INDEPENDENT AUDITORS



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



TO: The Secretary

NOV 14 2016

Through: DS \_\_\_\_\_  
COS \_\_\_\_\_  
ES \_\_\_\_\_FROM: Inspector General *Daniel R. Levinson*

DATE: November 14, 2016

SUBJECT: OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2016 (A-17-16-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2016 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the HHS (1) consolidated balance sheets as of September 30, 2016 and 2015, and the related consolidated statements of net cost and changes in net position; (2) the combined statements of budgetary resources for the years then ended; and (3) the statement of social insurance as of January 1, 2016, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 15-02, *Audit Requirements for Federal Financial Statements*.

**Results of the Independent Audit**

On the basis of its audit, Ernst & Young found that the FY 2016 HHS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. With respect to the estimates for the statement of social insurance as of January 1, 2016 and 2015, and the related Statement of Changes in Social Insurance Amounts, HHS management described in the financial statement footnotes the Medicare Board of Trustees alternative scenario that illustrates, when possible, the

## Page 2 – The Secretary

potential understatement of Medicare cost and projection results. This scenario assumes that the various cost-reduction measures will occur as current law requires. The most important of these measures are the reduction in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the specified physician updates put in place by the Medicare Access and CHIP<sup>1</sup> Reauthorization Act of 2015 (MACRA) (P.L. No. 114-10)—will occur as current law requires. Also, the Medicare Board of Trustees, in its annual report to Congress, stated:

The Trustees are hopeful that U.S. health care practices are in the process of becoming more efficient as providers anticipate more modest rates of reimbursement growth, in both the public and private sectors, than those experienced in recent decades. The methodology for projecting Medicare finances assumes a substantial long-term reduction in per capita health expenditure growth rates relative to historical experience, to which the cost-reduction provisions of the Affordable Care Act<sup>2</sup> and MACRA would add substantial savings. Notwithstanding recent favorable developments, current-law projections indicate that Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation.

The range of the social insurance liability estimates in the various scenarios is significant. As a result, Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2016, 2015, 2014, 2013, and 2012, and the related statements of changes in social insurance amounts for the periods ended January 1, 2016 and 2015. Ernst & Young was not able to, and did not, express an opinion on the financial condition of the HHS social insurance program and related changes in the social insurance program for the specified periods.

Ernst & Young also noted three matters involving internal controls with respect to financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, issued by the Comptroller General of the United States, Ernst & Young identified a material weakness in HHS's Financial Information Systems and significant deficiencies in both its Financial Reporting Systems, Analyses, and Oversight and the National Institutes of Health (NIH) Financial Management Systems and Review Processes:

- *Financial Information Systems*—Ernst & Young noted that HHS had continued to make strides to improve controls that support the information technology (IT) infrastructure and financial application system. The Material Weakness Working Group has continued to take a leadership role in monitoring activities across all HHS IT systems in scope for the consolidated financial statement audit and the Federal Information Security Modernization Act of 2014. Ernst & Young noted improvements occurred as a result of investments in the key financial systems' underlying infrastructure, proactive remediation of issues identified that allowed the risk to be modified, and the strengthening of the

<sup>1</sup> Children's Health Insurance Program.

<sup>2</sup> The Patient Protection and Affordable Care Act (P.L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. No. 111-152) are collectively referred to as the Affordable Care Act."

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departmentwide Plan of Actions and Milestone process that has led to the remediation of a number of prior-year findings. As in previous fiscal years, Ernst & Young indicated a focused effort is still needed to completely remediate long outstanding deficiencies related to segregation of duties, configuration management, and access to HHS financial systems. The deficiencies continue to represent a material weakness in internal control.

- *Financial Reporting Systems, Analyses, and Oversight*—During the FY 2016 audit, Ernst & Young continued to note progress in certain areas to improve HHS's and its Operating Divisions' financial management processes. While progress has continued, the FY 2016 audit, as in prior years, identified internal control deficiencies in financial systems and processes for producing financial statements, including a lack of integrated financial management systems and insufficient analysis of certain accounts. Ernst & Young continued to note that HHS did not consistently perform controls to ensure that differences were properly identified, researched, and resolved in a timely manner, and account balances were complete and accurate. Ernst & Young concluded that additional improvements in the financial reporting systems and processes are required. These deficiencies collectively constitute a significant deficiency in internal control.
- *NIH Financial Management System and Review Processes*—In FY 2016, Ernst & Young noted that the National Institutes of Health (NIH) performed additional analysis of its balances and invested resources to overcome certain deficiencies in its internal controls supporting IT infrastructure and financial application systems. Ernst & Young, however, continued to identify deficiencies that require additional focus. It identified deficiencies in the financial reporting process in which certain transactions are not reported consistently, resulting in differences that require research and manual posting of entries to ensure the financial information is synchronized between NIH and U.S. Treasury financial records, manual journal entries had improper or no approvals or insufficient support, and the lack of specific NIH procedures for its period-end closing to ensure all entries had been recorded appropriately or were complete. The deficiencies collectively constitute a separate significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2016, HHS was not in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended, and section 6411 of ACA related to the implementation of recovery activities for the Medicare Advantage program. HHS reported improper payment error rates for its high-risk programs, except for Temporary Assistance for Needy Families (TANF). HHS believes it does not have the authority under the Social Security Act to compel the States to report error rates for TANF. HHS reported an error rate of over 10 percent for the Medicare Fee-for-Service and Medicaid programs, which is a violation of the IPIA. Three other HHS high-priority programs reported error rates that did not meet their FY 2016 target error rates, which is another violation of the IPIA. We will report further on agency compliance with improper payment reporting, as required by the IPIA, later in FY 2017. HHS's management determined that it may have potential violations of certain provisions of the Anti-Deficiency Act (P.L. No. 101-508 and OMB Circular A-11) related to FY 2015 and FY 2016 obligation of funds for conference spending. HHS's management also determined that the agency's Medicare appeals process did not adjudicate appeals within the statutory timeframes required by the Social Security Act (P.L. No. 74-271).

## Page 4 – The Secretary

On the basis of the material weakness reported over Financial Information Systems and the significant deficiencies reported over Financial Reporting Systems, Analysis, and Oversight and NIH Financial Management System and Review processes, Ernst & Young concluded that HHS also did not comply with the Federal Financial Management Improvement Act of 1996 (P.L. No.104-208).

### Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 15-02, we reviewed Ernst & Young's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation, including those related to the review of internal controls over financial reporting;
- reviewing the auditors' reports, and;
- reviewing the HHS *FY 2016 Agency Financial Report*.

Ernst & Young is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996, or HHS's compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Gloria L. Jarmon, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at [Gloria.Jarmon@oig.hhs.gov](mailto:Gloria.Jarmon@oig.hhs.gov). Please refer to report number A-17-16-00001.

Attachment

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cc:

Ellen Murray

Assistant Secretary for Financial Resources  
and Chief Financial Officer

Sheila Conley

Deputy Assistant Secretary, Finance  
and Deputy Chief Financial Officer





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## Report of Independent Auditors

The Secretary and the Inspector General of the  
U.S. Department of Health and Human Services

### Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (HHS) as of September 30, 2016 and 2015, and the related consolidated statement of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements. We were also engaged to audit the statement of social insurance as of January 1, 2016, 2015, 2014, 2013, and 2012, the related statement of changes in social insurance amounts for the periods ended January 1, 2016 and 2015, and the related notes to these financial statements.

### *Management's Responsibility for the Financial Statements*

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

### *Auditor's Responsibility*

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statement of social insurance as of January 1, 2016, 2015, 2014, 2013, and 2012, the related statement of changes in social insurance amounts for the periods ended January 1, 2016 and 2015, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*. Those standards and bulletin require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to HHS's preparation and fair presentation of the financial statements in order to design

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audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2016 and 2015, and the related consolidated statement of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements.

***Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Related Changes in the Social Insurance Program***

As discussed in Note 24 to the principal financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA).

As further described in Note 25 to the principal financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2016, 2015, 2014, 2013, and 2012, management has assumed in the projections of the program that the various cost-reduction measures will occur as the ACA and the specified physician updates established by MACRA require. Management has developed an illustrative alternative scenario and projections intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 25, the ability of health care providers to sustain these price reductions will be challenging, as the best available



evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for most health services will fall increasingly short of the costs of providing these services. For example, overriding the scheduled physician payment updates or the productivity adjustments for most providers, as was done repeatedly with the sustainable growth rate formula in the period leading up to passage of MACRA and may be necessary in the future if cost rates prove inadequate, would lead to substantially higher costs for Medicare in the long range than those projected in this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statement of social insurance as of January 1, 2016, 2015, 2014, 2013, and 2012, and the related statement of changes in social insurance amounts for the periods ended January 1, 2016 and 2015.

***Disclaimer of Opinion on the Statement of Social Insurance and the Related Changes in the Social Insurance Program***

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the HHS social insurance program as of January 1, 2016, 2015, 2014, 2013, and 2012, and the related changes in the social insurance program for the periods ended January 1, 2016 and 2015.

***Opinion***

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of HHS as of September 30, 2016 and 2015, and its consolidated net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

***Other Matters***

***Required Supplementary Information***

U.S. generally accepted accounting principles require that the Management's Discussion and Analysis, Required Supplementary Stewardship Information, and Required Supplementary Information as identified on HHS's Agency Financial Report Table of Contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Federal Accounting Standards Advisory Board, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards



generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

#### ***Other Financial Information and Other Information***

Our audits were conducted for the purpose of forming opinions on the financial statements that collectively comprise HHS's basic financial statements. The Other Financial Information, as identified on HHS's Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the basic financial statements.

The Other Financial Information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audits of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the Other Financial Information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Except for the Other Financial Information described above, the Other Information has not been subjected to the auditing procedures applied in the audits of the basic financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

#### ***Other Reporting Required by Government Auditing Standards***

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 14, 2016, on our consideration of HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control over financial reporting and compliance.

*Ernst & Young LLP*

November 14, 2016

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## Report of Independent Auditors on Internal Control over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

The Secretary and the Inspector General of the  
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2016, and the related consolidated statement of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the principal financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2016, and the related statement of changes in social insurance amounts for the period ended January 1, 2016, and have issued our report thereon dated November 14, 2016. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2016, and the related statement of changes in social insurance amounts for the period ended January 1, 2016.

### Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS's internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 15-02. We did not test all internal controls relevant to operating objectives as broadly defined by the *Federal Managers' Financial Integrity Act of 1982*, such as those controls relevant to ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of

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deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies; therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit, we did identify certain deficiencies related to Financial Information Systems, described below, to be a material weakness. We also identified certain deficiencies related to Financial Reporting Systems, Analyses, and Oversight, and National Institutes of Health (NIH) Financial Management Systems and Review Processes, described below, to be significant deficiencies.

## **Material Weakness**

### ***Financial Information Systems***

The Department continued to make strides during fiscal year (FY) 2016 to improve the controls within its supporting information technology (IT) infrastructure and financial systems. The Material Weakness Working Group (MWWG) has continued to take a leadership role in monitoring remediation activities across all IT systems in scope of the consolidated Financial Statement Audit and *Federal Information Security Modernization Act of 2014* (FISMA). The MWWG has effectively altered the culture and “tone at the top” by putting a heightened focus on addressing the root cause of issues identified during the audit, resulting in a more mature controls environment across the Department. The following summarizes some of the improvements achieved that resulted from this increased attention:

- Differential investments in key financial systems’ underlying infrastructure (i.e., Oracle upgrades and movement to the cloud), providing a more modern and mature controls baseline that positions the Department well for future scalability in an efficient manner;
- Proactive remediation of issues identified during the audit, allowing for the residual risk of the issue to be minimized, while establishing the processes necessary to close the issue moving forward; and
- Strengthening of the Department-wide Plan of Actions and Milestone (POA&M) process, which has led to the remediation of a number of prior year objective attributes recap sheet (OARS) items.

Although the MWWG has implemented specific action plans to decrease the number and severity of the deficiencies remaining in the major financial systems, the remediation of deficiencies, which sometimes takes multiple years, is inherently an iterative process. A focused risk-driven effort is still necessary to completely remediate the remaining long-outstanding deficiencies in the areas of



access controls, configuration management, and segregation of duties (SOD). The remaining deficiencies continue to constitute an IT material weakness in internal control. We grouped the deficiencies into the following topics and categories listed below:

- Access controls
  - Inconsistently performing user access reviews of generic IDs, some with administrative access, which impacts the ability to effectively identify and monitor access anomalies and other potentially suspicious activities
  - Users maintaining multiple user IDs to the application and/or users with excessive application access that is not commensurate with their job roles and responsibilities
- Configuration management
  - Understanding the full population of changes made to an application and verifying that no changes were made to a system that did not go through the change approval and management process
- Segregation of duties
  - Limited role-based security implementation and established policies and procedures supporting role-based security
  - Inconsistent implementation of least privileged access considerations for all users and limited documentation regarding business justifications for identified SOD conflicts

The following is a summary of the deficiencies that we considered most critical. When we assess the deficiencies in aggregate, we continue to conclude they could have a material effect on the financial statements, and as a result, this forms the basis for our conclusion of an IT material weakness:

- Access controls – We identified access controls exceptions across eight of the nine applications in scope of our review, which spanned HHS and NIH. Specifically, we noted (1) audit logs are used to monitor user access and activity, but the audit logs are not reviewed/monitored on a consistent basis, (2) user activity is not consistently reviewed for suspicious or malicious activity, (3) shared user IDs, some with privileged access, are used without monitoring user activity performed when using the shared IDs in question, (4) allowing the use of multiple user IDs creates the risk of individuals performing activities that may violate segregation of duties, and (5) several systems had issues identified within the new user provisioning process to include an incomplete set of roles identified for access provisioning forms, and access being provisioned prior to receipt of required approvals. Similarly, the Centers for Medicare & Medicaid Services (CMS) did not perform or adequately perform management reviews of user access and system parameters for key financially significant applications. In addition, procedures for adding or removing users were not consistently followed.
- Configuration management – We identified configuration management exceptions in seven of the nine applications in scope of our review, which spanned HHS and NIH. Specifically,



we noted (1) configuration management and release management standard operating procedures were not developed or implemented across the span of the audit, (2) applications are not maintaining updated baseline configurations for certain aspects of the application, to include back-end database and operating system, and (3) we were not able to validate the full population of changes made to an application in order to verify that only changes that went through the change management and approval process were put into production. CMS continues to experience deficiencies in the implementation and monitoring of compliance with its defined computer security policies at both the Medicare fee-for-service contractors and the Central Office. Several vulnerabilities related to system configurations were identified with the Central Office and Medicare fee-for-service information systems. In several instances, the remediation, mitigation of risks, or monitoring of these vulnerabilities was not performed or not performed in a timely manner. In addition, evidence supporting the authorization and testing of claims processing software changes, application production support fixes, and infrastructure changes were not always retained and/or performed.

- Segregation of duties – We identified segregation of duties exceptions across four of our nine applications in scope of our review, which spanned HHS and NIH. Specifically, we noted (1) policies and procedures required to enforce segregation of duties among various roles have not been finalized and approved, (2) documented segregation of duties matrices have not been finalized by management and are still in draft form, (3) listing of all users with SOD conflicts and their respective business justifications is not proactively maintained, and (4) the use of multiple user IDs creates the risk of individuals performing functions that may violate SOD requirements. CMS continues to experience difficulties in implementing adequate segregation of duties. In addition, we identified users for two Central Office applications that were provided additional administrator rights.

### Recommendations

HHS should continue the focus achieved in FY 2016 to remediate the remaining deficiencies contributing to material weakness. The following are some specific considerations:

- Continue to identify, assess, modify, and monitor access controls, configuration management, and segregation of duties to further enhance the security posture of all applications. Specific recommendations for the non-CMS Operating Division (OpDiv) applications are included within the respective OARS for each application in scope.
- A focused effort should be made to decommission systems that are being planned to retire based on the implementation of the new system in which the Department is no longer making a differential investment in remediating the issues identified within the system.





- We have performed a separate financial statement audit of CMS for FY 2016 and, in conjunction with our reports on that audit, have provided recommendations specific to CMS on our IT internal control findings. Those findings and recommendations were considered in our overall HHS conclusions.

### **Significant Deficiencies**

#### ***Financial Reporting Systems, Analysis, and Oversight***

Although progress in certain areas has been identified, HHS and its OpDivs' internal reviews and the results of our testing of internal control have continued to identify internal control deficiencies in financial systems and processes for producing financial statements, including lack of integrated financial management systems and insufficient analysis of certain significant accounts. In many cases, processes continued to be developed throughout FY 2016 and will require additional refinements in FY 2017 and beyond. Within the context of the approximately \$1 trillion in departmental net outlays, the ultimate resolution of our specific 2016 findings was not material to the consolidated financial statements taken as a whole. However, these matters are indicative of systemic issues that should continue to be resolved.

#### ***Lack of Integrated Financial Management System***

Over the past 19 years, HHS has continued its efforts to overcome issues that have affected its ability to become compliant with the *Federal Financial Management Improvement Act of 1996* (FFMIA), including long-standing issues for which HHS and the audit have identified and reported in the past. For example:

- HHS records approximately \$1.1 trillion in manual journal entries to ensure balances within financial systems are correct.
- As discussed above, departures from requirements specified in OMB A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, and OMB A-130, *Management of Federal Information Resources*, related to access and change management controls within financial systems continue to be identified.
- The lack of sufficient integration within certain financial systems is not complemented with sufficient manual preventative and detective-type controls, including the NIH Business System (NBS), which continues to utilize two separate processes to report budgetary and financial statement activity and which requires significant manual periodic reconciliations to identify differences for research to ensure appropriate accounting in both processes.
- Although CMS utilizes the Healthcare Integrated General Ledger Accounting System (HIGLAS) in preparing its financial statements, the full functionality of HIGLAS has not



yet been implemented. CMS's durable medical equipment (DME) Medicare Administrative Contractors (MACs) have not fully implemented CMS's HIGLAS. For these contractors, the accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to CMS and, ultimately, HHS for consolidation.

Resource limitations and other priorities have consistently been identified as the causes for delays in upgrading certain system and financial internal control processes limiting HHS's ability to comply with requirements under FFMIA.

With the ongoing implementation of the *Digital Accountability and Transparency Act* (the DATA Act) and the completed upgrades of its financial systems, HHS has made progress in addressing its compliance with FFMIA. As it continues its pursuit in resolving these long-standing issues, HHS should continue in developing, maintaining, and implementing consistent policies and procedures, monitoring the implementation of its upgrades, providing extensive training throughout the Department to ensure consistent application, and enhancing its monitoring program to ensure continued compliance.

#### ***Financial Analysis and Oversight***

Because deficiencies continue to exist in the financial management systems, management must compensate for the deficiencies by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of deficiencies that may impact HHS's ability to report accurate financial information on a timely basis. Although certain improvements were noted, similar to prior years, we found that certain controls were not consistently performed to ensure that differences were properly identified, researched, and resolved in a timely manner and that account balances were complete and accurate. We identified the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required:

#### ***Operating Division Periodic Analysis and Reconciliation***

As deficiencies exist in financial systems, management compensates by implementing and strengthening other manual controls to ensure that errors and irregularities are prevented or detected in a timely manner. These manual and compensating controls may include monitoring of budgets, reconciliations of accounts, analyses of fluctuations, aging of accounts, and manual and supervisory reviews. During our audit, we found that certain controls still required further improvements. The following represent specific areas that need enhanced periodic reconciliation and analysis:



- Manual Journal Entries* – During FY 2016, although significant progress was made in certain OpDivs with the automation of certain transactions, more than 15,000 manual journal entries totaling approximately \$1.1 trillion in absolute value were recorded in the Unified Financial Management System (UFMS) and NBS to post certain types of routine and non-routine transactions – including transactions to record proprietary and budgetary entries, record accruals, perform adjustments between governmental and nongovernmental accounts, perform adjustments to agree budgetary to proprietary accounts, perform other reconciliation adjustments at period-end, and correct errors identified as related to configuration issues within UFMS and NBS. These entries are posted to UFMS and NBS to record both the proprietary and budgetary effects of financial activities for which the financial system may not be configured properly to post automatically. Although these entries are required to be posted to the general ledger in order for the financial statements to be accurate, many of these entries should be configured as routine systematic entries within the systems. HHS’s management indicated that it continues to develop and implement corrective actions to reduce the number of manual journal entries in future years.
- Commissioned Corps* – During January 2014, HHS transferred the Commissioned Corps retiree payroll processes from a commercial financial shared service center to the U.S. Coast Guard. During FY 2015 and FY 2016, we determined that reviews of the respective Coast Guard internal control systems had not sufficiently taken place during the respective fiscal years nor had sufficient communications taken place to ensure timely access of Commissioned Corps data or documentation for audit purposes. HHS management has indicated that steps are being taken to ensure effective internal controls and appropriate access are available over its Commissioned Corps data.
- Civilian Payroll Process* – HHS processes its civilian payroll through a series of computer systems and internal controls. During our FY 2016 audit, we noted certain internal control lapses, including the following: an incorrect pay calculation due to out-of-date personnel data entered on a new hire; information discrepancies between the two payroll systems which, resulted in inconsistencies in employee elections and deductions; and improper system updates, which resulted in untimely payroll reconciliations and untimely provisions of required personnel supporting documentation. We also observed deficiencies related to IT security, specifically relating to access and segregation of duties within certain payroll-related systems. HHS has indicated that it is working to resolve these control issues by strengthening IT security and manual controls.
- Grant Accrual Process* – For more than 15 years, HHS’s Payment Management Service has utilized a linear regression analysis of its grant advance and disbursement amounts to derive a quarterly grant accrual for each of its OpDivs. In the first quarter of FY 2016, the process was automated to allow for a more timely and less labor-intensive calculation to be produced. During our interim audit procedures, we were able to recalculate the grant



accrual based on the linear methodology without exception. During our procedures at year-end, we noted differences totaling approximately \$1 billion between our calculation using the linear regression analyses and the HHS-calculated accrual for 9 out of 10 OpDivs. The Payment Management Service indicated that they modified the fourth quarter accrual using the linear regression analysis based on calculating a growth estimate and net adjustment for new programs, followed up with look-back methodologies to confirm reasonableness of the modified accruals. As part of our audit procedures to substantiate the modified amounts, we were unable to obtain formalized policies documenting the new approach or monthly/periodic analysis to substantiate the adjustments.

#### ***Financial Management Controls at CMS***

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on its internal controls dated November 4, 2016. In that report, we outlined details of deficiencies noted and made recommendations for improvement in its financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies and those related to business partner risk management, noted elsewhere in this report, to be a significant deficiency for the CMS internal control over financial reporting.

Our observations related to financial management controls included a recommendation that as CMS continues to enhance its data analyses capability, further improvement can be made by developing robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. To the extent more robust analysis occurs within Centers and Offices, identifying, evaluating, and reviewing such analysis would assist in ensuring that a perspective that incorporates a financial reporting point of view is captured and considered. It may be beneficial for CMS to identify a cross-functional working group to perform such analysis.

#### ***Business Partner Risk Management at CMS***

CMS relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Medicare Part C and Part D programs. We identified areas where improvements could be made in the control environment related to the oversight of third-party contractors.

The contracts between CMS and its Medicare fee-for-service contractors include provisions that require the MACs to develop policies and procedures that satisfy the objectives established by CMS. Through the established procedures, CMS monitors the MACs' compliance with its policies and procedures, established internal controls, and the completeness and accuracy of financial reporting. While this approach to financial integrity supports CMS's role in the monitoring of the



MACs' financial controls, the oversight/monitoring process historically has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that the issues are remediated in a timely manner by the MACs.

As noted in the prior year, we identified deficiencies where actions are required but have not been taken or resolved in the following circumstances: (1) the Medicare Summary Notices, which are returned to the MACs but are not investigated as to why they are returned; (2) the claims outstanding greater than one year – periodically review, track, or monitor those aged claims other than those identified as bankruptcy, fraud, or abuse; and (3) the provider records – reconcile, review, or monitor provider records and provider eligibility status on a periodic basis to verify that all changes were processed in a timely, accurate, and complete.

### Recommendations

We recommend that HHS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. Specifically, we recommend that HHS perform the following:

- Continue to move forward to prioritize and centralize additional resources in addressing issues related to controls within and surrounding its financial information management systems.
- When all of the Federal Financial Reports (FFRs) for the quarter ended September 30, 2016 have been received, perform a look back analysis to the year-end grant accrual estimate. Using that analysis re-assess the grant accrual regression analysis and the need for the manual adjustments to that model made for the 2016 year-end close. Necessary revisions, if any, to the accrual process should be standardized to assure consistency of the process for each close. HHS should fully document any changes required to the model and processes. The adjusted policies should include providing monthly and/or quarterly documented analysis for each OpDiv to support the changes made to the automated linear regression analysis in determining the final grant accrual estimates so that OpDiv grants managers and financial management offices can complete their analysis and challenge of the fair presentation of the OpDiv financial statements.
- Continue to focus on automating and reducing the number of manual journal entries by determining the cause and the ability to upgrade systems to allow for automated posting of high-volume routine transactions and to ensure financial data is accurate. Additionally, we believe that HHS should strengthen controls surrounding review and approval functions around manual journal entries and reconciliations to provide for timely identification of errors and remediation of differences.



- Continue to focus on enhancing systematic and manual internal controls surrounding civilian payroll and Commissioned Corps data.

Additionally, we recommend that CMS continue to develop and refine its financial management controls and business partner risk management as a means to improve its accounting, analysis, and oversight of financial management activity. More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

#### ***NIH Financial Management Systems and Review Processes***

Although NIH upgraded its core financial system (NBS), performed additional analysis of its balances, and invested both HHS and NIH resources in overcoming certain deficiencies in its internal controls supporting information technology (IT) infrastructure and financial application systems in FY 2015 and FY 2016, NIH and our audit continue to identify deficiencies that require additional focus in FY 2017 and beyond. For example:

- *Financial Reporting Processes* – Beginning in FY 2014, Treasury required that agencies utilize its governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) to submit not only its required budgetary reporting, but its financial activities for purposes of developing the governmentwide financial statements. Treasury guidance also indicated that the balances reported in the agencies financial statements should be consistent with that included within GTAS. For GTAS, NIH produces bulk files using a web-based SQL server tool, which pulls data from NBS and allows for adjustments related to timing and reclassification differences to be made within the tool prior to GTAS submission. Whereas, financial statement activity is reported directly from NBS to Consolidated Financial Reporting System (CFRS). These two separate processes of reporting budgetary and financial statement activity require significant periodic reconciliations and may create significant differences between GTAS and CFRS. Due to timing differences, certain transactions are not reported consistently between processes, resulting in differences that require research and manual posting of entries to ensure both systems are synchronized after the end of the period. NIH management has indicated that it plans to better align its budgetary and financial reporting processes in order to ensure consistency and appropriate accounting.

Additionally, we noted that NBS does not electronically enforce some controls and sound accounting practices included in the HHS Accounting Treatment Manual. For example, we noted that NBS does not automatically close certain accounts and allows users to reopen previously closed periods. As a result additional analysis and manual adjustments are required to ensure the system will open in the next period with the proper beginning balances.



- *Manual Journal Entries* – As discussed above, HHS posts a significant number of manual journal entries, with the majority of the entries being generated by NIH. During FY 2016, although NIH's annual total budgetary resources was only \$38 billion, NIH was required to process approximately 13,000 manual journal entries totaling an absolute value of more than \$897 billion to its NBS. These entries consist of nonstandard postings to record both the proprietary and budgetary effects of certain financial activities for which either the financial system is not configured properly to post automatically or to correct differences identified within the critical reconciliation processes of NBS to its subsidiary systems or GTAS balances to CFRS. Although necessary to ensure balances are accurate, the number of manual journal entries is significant compared to the NIH's overall activity.

Additionally, we observed certain weaknesses in the manual journal entry process, including:

- Improper or lack of approvals to both routine and non-routine manual journal entries
- Allowing for the posting of certain entries that were inappropriate and required reversal
- Limited descriptions as to the purpose of the manual journal entry
- Insufficient controls and processes to determine what entries are routine and if all required entries were recorded in the proper period and for each period
- Insufficient documentation to support the purpose of certain non-routine entries

Our analysis of those entries did not cause us to change our opinion on the FY 2016 financial statements of HHS taken as a whole. However, we identified instances in which the research of the differences was inadequate, the supporting documentation underlying the manual journal entries was insufficient, and the HHS manual journal entries approval process was not followed. NIH management indicated that the reason for the large number of manual journal entries is due to system and resource limitations, the need to develop NIH-specific policies, and enhanced training of its personnel.

- *NIH's Grant Accrual* – Quarterly, NIH recorded an estimated grant accrual to its financial data to ensure that reported financial statement balances were correct. Although the grant accrual supports all 27 institutes for each of the current six years of appropriations, NIH records its estimate to only one institute's appropriation. At September 30, 2016, the estimated grant accrual totaled \$5.3 billion. NIH management indicated that at quarter-end, there was insufficient time to post an estimate to each of its approximately 200 appropriations. Additionally, the process is recorded through a manually intensive entry process that would increase the chance for mistakes during the posting in the current month and the reversal during the future period.



- *Policies and Procedures* – Although HHS has created a tracking system to develop and implement new policies, NIH has not taken the next step in developing NIH-specific desk procedures for its period-end closing to ensure all entries are recorded appropriately and complete.
- *IT System Infrastructure* – During our FY 2016 audit, we continue to identify deficiencies related to IT security, specifically relating to access and segregation of duties within NBS. NIH has indicated that it is working to resolve certain control issues by strengthening IT security and manual controls.

### Recommendations

We recommend that NIH:

- Analyze its routine manual journal entries to determine if certain entries should be configured within the NBS to limit the number of higher-risk entries.
- Enhance its internal control processes related to manual journal entries, including the development of NIH-specific procedures and training to ensure its policy is consistently applied. The policies should suggest developing a log of routine entries to ensure all postings are complete and appropriate. Additionally, we recommend the level of authorization be documented, especially for non-routine high-risk entries, and that minimum documentation supporting the entry be maintained.
- Continue to focus efforts in remediating internal control issues related to IT infrastructure and systems controls for its NBS.
- Develop a process to reasonably allocate NIH's grant accruals to each of its 27 institutes to allow for accurate GTAS reporting.
- Evaluate NIH's budgetary and financial reporting processes to better enable for consistent reporting and more timely determination of differences between the two processes.
- Develop monthly analyses prepared for the audit which should be formalized and made a part of the accounting records of NIH. In addition, the analysis and adjustment processes related to balances at NIH should be revised to assure differences are thoroughly researched and adjustments are properly documented and approved.





### *Status of Prior Year Findings*

In the reports on the results of the FY 2015 audit of the HHS financial statements, a number of issues were raised relating to internal control over financial reporting. The chart below summarizes the current status of the prior year items:

Material Weakness		
Issue Area	Summary Control Issue	FY 2016 Status
Financial Management Information Systems	<ul style="list-style-type: none"> <li>• Segregation of Duties</li> <li>• Configuration Management</li> <li>• Access Controls</li> <li>• FISMA Compliance</li> </ul>	Certain progress noted; certain issues need continued focus Modified Repeat Condition
Significant Deficiencies		
Financial Reporting Systems, Analyses, and Oversight	<ul style="list-style-type: none"> <li>• Lack of Integrated Financial Management System</li> <li>• Financial Analysis and Oversight</li> </ul>	Progress noted; however, certain issues identified require continued focus; Modified Repeat Condition
NIH Financial Management Close and Review Processes	<ul style="list-style-type: none"> <li>• Documentation to support NIH review and approval process is insufficient.</li> </ul>	Progress noted; however, certain issues identified require continued focus; Modified Repeat Condition

### **HHS's Response to Findings**

HHS's response to the findings identified in our audit and examination are included in the accompanying letter dated November 14, 2016. HHS's response was not subjected to either the auditing procedures applied in the audit of the financial statements or the attest procedures applied in the examination of internal control, and, accordingly, we express no opinion on it.

### **Purpose of This Report**

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing, and not to provide an opinion on the entity's internal control. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control. Accordingly, this communication is not suitable for any other purpose.

*Ernst & Young LLP*

November 14, 2016

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## Report of Independent Auditors on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance With *Government Auditing Standards*

The Secretary and the Inspector General of the  
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the Office of Management and Budget (OMB) Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2016, and the related consolidated statement of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the principal financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2016, and the related statement of changes in social insurance amounts for the period ended January 1, 2016, and have issued our report thereon dated November 14, 2016. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2016, and the related statement of changes in social insurance amounts for the period ended January 1, 2016.

### Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 15-02, including the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA) (P.L.104-208). However, providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit, and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to HHS.

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The results of our tests of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 15-02, as described below.

During fiscal year (FY) 2016, HHS's management determined that it may have potential violations of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to FY 2015 and FY 2016 obligation of funds for conference spending. Additionally, HHS's management determined that its Medicare appeals process did not adjudicate appeals within the statutory decisional time frames required by the *Social Security Act*.

The *Improper Payments Information Act of 2002* (IPIA) (P.L. 107-300) as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) (P.L. 111-204) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (P.L. 112-248) (hereinafter, the "Acts") require federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. While the Department continues to make progress, HHS currently is not in full compliance with the requirements of the Acts. For example, HHS has reported improper payment error rates for each of its high-risk programs, or components of such programs, except for the Temporary Assistance for Needy Families (TANF). HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement for TANF due to Section 411 of the Social Security Act, which specifies the data elements that HHS may require states to report, and Section 417 of the same *Social Security Act*, which dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS feels that it does not have the authority to collect data pertaining to case and payment accuracy for TANF since the information is not included under the *Social Security Act*. Additionally, we noted certain high-risk programs that did not meet their identified targets or exceeded the maximum 10% threshold stipulated by OMB. Also, HHS is not in full compliance with Section 6411 of the *Patient Protection and Affordable Care Act*, as HHS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program. HHS indicated it remains committed to implementing this provision of the Affordable Care Act, and anticipates awarding a Medicare Part C Recovery Audit Contractor contract in 2017.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed instances in which HHS's financial management systems did not substantially comply with certain requirements as discussed above. We have identified the following instances of noncompliance related to FFMIA:

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- During FY 2016, HHS recorded approximately \$1.1 trillion in manual journal entries, as these transactions are not currently configured correctly within the financial systems and are for the purpose of ensuring that balances within financial systems are correct to enable the development of periodic financial statements and other required reporting.
- The lack of sufficient integration within certain financial systems are not complemented with sufficient manual preventative and detective-type controls, including the NIH Business System, which continues to utilize two separate processes to report budgetary and financial statement activity and which requires significant periodic manual reconciliations to identify differences for research to ensure appropriate accounting in both processes.
- Although the Centers for Medicare & Medicaid Services (CMS) utilizes the Healthcare Integrated General ledger Accounting System (HIGLAS) in preparing its financial statements, the full functionality of HIGLAS has not yet been implemented. CMS's durable medical equipment (DME) Medicare Administrative Contractors (MACs) have not fully implemented CMS's HIGLAS. For these contractors, the accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to CMS and, ultimately, HHS for consolidation.
- Although progress was noted, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB A-130, *Management of Federal Information Resources*, and OMB A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. Additionally, the Office of Inspector General (OIG) identified certain issues, including access control deficiencies related to systems as part of its Federal Information Security Management Act and other OIG engagements. Finally, HHS management has identified certain weaknesses within its information technology general and application controls during its assessment of corrective action status and its OMB A-123 processes.

\* \* \* \* \*

### HHS's Response to Findings

Our Report on Internal Control dated November 14, 2016, includes additional information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance to FFMIA, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented and that relevant comments from HHS's management responsible for addressing the noncompliance are provided in its letter dated November 14, 2016. HHS's response was not subjected to either the auditing procedures applied in the audit of the financial statements or the attest procedures applied in the examination of internal control, and, accordingly, we express no opinion on it.

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Additionally, HHS is updating its Department-wide corrective action plan to address FFMIA and other financial management issues.

**Purpose of This Report**

The purpose of this report is solely to describe the scope of our testing of compliance and the results of that testing, and not to provide an opinion on HHS's compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's compliance. Accordingly, this communication is not suitable for any other purpose.

*Ernst & Young LLP*

November 14, 2016

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## DEPARTMENT'S RESPONSE TO THE REPORT OF THE INDEPENDENT AUDITORS



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: Ellen G. Murray, Assistant Secretary for Financial Resources and Chief Financial Officer

Subject: FY 2016 Financial Statement Audit

We appreciate the opportunity to comment on the Independent Auditors' Report concerning the audit of our FY 2016 financial statements. We are pleased that the independent auditors found HHS's FY 2016 financial statements and notes were presented fairly, in all material respects, and in conformity with the U.S. generally accepted accounting principles. In response to their Report on Internal Control, we generally concur with their findings and are prepared to develop corrective action plans to address those findings. HHS leadership is dedicated to effectively resolving our challenges.

Central to HHS's information technology (IT) remediation effort is the establishment of a cross-Department, cross-functional IT Material Weakness Working Group (IT MWWG), which has met monthly since inception in June 2015. The IT MWWG is working on two fronts – coordinating responsive efforts to address current audit findings and vulnerabilities, as well as proactive efforts to mature the security and controls environment going forward. With regard to current findings, the IT MWWG has coordinated with system owners across the Department to resolve issues, identify target completion dates, and monitor progress. The size and complexity of our IT environment continues to pose substantial challenges as we address weaknesses across multiple systems, organizations, and business processes.

The Department's progress to address our significant deficiencies can be attributed to a robust and structured corrective action planning process sustained through effective communication and collaboration with the Operating Divisions. Corresponding policy, guidance, training, and on-site technical assistance to the Operating Divisions are key components of the process.

We take remediation of our deficiencies seriously and we will continue to focus our efforts and resources on addressing our longstanding and complex financial reporting audit findings. Under the strategic direction of the HHS Risk Management and Financial Oversight Board, the Department and its Operating Divisions are committed to sound financial management that delivers reliable and actionable information for both internal and external decision makers and stakeholders.

We would like to thank the Office of Inspector General (OIG) and our independent auditors, Ernst & Young LLP, for your efforts on our behalf. We appreciate the continued collaboration of the OIG to improve our stewardship and transparency of taxpayer funds.

/Ellen G. Murray/

Ellen G. Murray  
 Assistant Secretary for Financial Resources and  
 Chief Financial Officer  
 November 14, 2016

## PRINCIPAL FINANCIAL STATEMENTS

## U.S. Department of Health and Human Services

## Consolidated Balance Sheets

As of September 30, 2016 and 2015

(in Millions)

	2016	2015
<b>Assets (Note 2)</b>		
<b>Intragovernmental Assets</b>		
Fund Balance with Treasury (Note 3)	\$ 237,759	\$ 219,459
Investments, Net (Note 4)	262,077	269,651
Accounts Receivable, Net (Note 5)	1,012	1,005
Advances (Note 8)	239	178
<b>Total Intragovernmental Assets</b>	<b>501,087</b>	<b>490,293</b>
Accounts Receivable, Net (Note 5)	24,203	21,915
Inventory and Related Property, Net (Note 6)	9,399	9,516
General Property, Plant and Equipment, Net (Note 7)	5,665	5,917
Advances (Note 8)	21,480	33
Other Assets	819	1,121
<b>Total Assets</b>	<b>\$ 562,653</b>	<b>\$ 528,795</b>
<b>Stewardship Land (Notes 1 and 20)</b>		
<b>Liabilities (Note 9)</b>		
<b>Intragovernmental Liabilities</b>		
Accounts Payable	\$ 339	\$ 309
Other Liabilities (Note 13)	7,063	3,609
<b>Total Intragovernmental Liabilities</b>	<b>7,402</b>	<b>3,918</b>
Accounts Payable	981	574
Entitlement Benefits Due and Payable (Note 10)	108,230	108,149
Accrued Liabilities (Note 12)	14,420	14,250
Federal Employee and Veterans' Benefits (Note 11)	12,892	12,072
Contingencies and Commitments (Note 14)	12,394	9,105
Other Liabilities (Note 13)	4,963	3,320
<b>Total Liabilities</b>	<b>161,282</b>	<b>151,388</b>
<b>Net Position</b>		
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	35,912	30,184
Unexpended Appropriations - All Other funds	128,129	116,089
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	233,470	221,480
Cumulative Results of Operations - All Other funds	3,860	9,654
<b>Total Net Position - Funds from Dedicated Collections</b>	<b>269,382</b>	<b>251,664</b>
<b>Total Net Position - All Other Funds</b>	<b>131,989</b>	<b>125,743</b>
<b>Total Net Position</b>	<b>401,371</b>	<b>377,407</b>
<b>Total Liabilities and Net Position</b>	<b>\$ 562,653</b>	<b>\$ 528,795</b>

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements

**U.S. Department of Health and Human Services****Consolidated Statement of Net Cost**

For the Years Ended September 30, 2016 and 2015

(in Millions)

	2016	2015
<b>Responsibility Segments</b>		
Centers for Medicare & Medicaid Services (CMS)		
Gross Costs	\$ 1,044,615	\$ 1,011,350
Exchange Revenue	(91,964)	(98,030)
CMS Net Cost of Operations	952,651	913,320
Other Segments:		
Administration for Children and Families (ACF)	51,515	50,300
Administration for Community Living (ACL)	2,058	1,755
Agency for Healthcare Research and Quality (AHRQ)	348	359
Centers for Disease Control and Prevention (CDC)	12,098	10,517
Food and Drug Administration (FDA)	4,617	4,225
Health Resources and Services Administration (HRSA)	10,223	9,158
Indian Health Service (IHS)	6,204	6,158
National Institutes of Health (NIH)	30,790	29,985
Office of the Secretary (OS)	3,176	3,174
Program Support Center (PSC)	2,033	1,942
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,636	3,391
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	\$ 126,698	\$ 120,964
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan (Note 11)	483	(249)
Other Segments Gross Costs of Operations after Actuarial Gains and Losses	\$ 127,181	\$ 120,715
Exchange Revenue	(5,060)	(4,006)
Other Segments Net Cost of Operations	122,121	116,709
<b>Net Cost of Operations (Note 15)</b>	<b>\$ 1,074,772</b>	<b>\$ 1,030,029</b>

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.



## U.S. Department of Health and Human Services Consolidated Statement of Changes in Net Position

For the Year Ended September 30, 2016  
(in Millions)

	2016			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
<b>Cumulative Results of Operations:</b>				
Beginning Balances	\$ 221,480	\$ 9,654	\$ -	\$ 231,134
<b>Budgetary Financing Sources:</b>				
Other Adjustments (+/-)	-	(857)	-	(857)
Appropriations Used	323,452	495,197	-	818,649
Nonexchange Revenue				
Nonexchange Revenue - Tax Revenue	250,472	-	-	250,472
Nonexchange Revenue - Investment Revenue	9,938	17	-	9,955
Nonexchange Revenue - Other	3,980	-	-	3,980
Donations and Forfeitures of Cash and Cash Equivalents	80	-	-	80
Transfers-in/out without Reimbursement	(4,447)	2,768	-	(1,679)
Other (+/-)	-	1	-	1
<b>Other Financing Sources (Nonexchange):</b>				
Donations and Forfeitures of Property	-	7	-	7
Transfers-in/out Without Reimbursement (+/-)	(4)	7	-	3
Imputed Financing	38	736	(294)	480
Other (+/-)	134	(257)	-	(123)
Total Financing Sources	583,643	497,619	(294)	1,080,968
Net Cost of Operations (+/-)	571,653	503,413	(294)	1,074,772
Net Change	11,990	(5,794)	-	6,196
<b>Cumulative Results of Operations:</b>	<b>\$ 233,470</b>	<b>\$ 3,860</b>	<b>\$ -</b>	<b>\$ 237,330</b>
<b>Unexpended Appropriations:</b>				
Beginning Balance	\$ 30,184	\$ 116,089	\$ -	\$ 146,273
<b>Budgetary Financing Sources:</b>				
Appropriations Received	351,309	596,875	-	948,184
Appropriations Transferred in/out	-	(16)	-	(16)
Other Adjustments	(22,129)	(89,622)	-	(111,751)
Appropriations Used	(323,452)	(495,197)	-	(818,649)
Total Budgetary Financing Sources	5,728	12,040	-	17,768
Total Unexpended Appropriations	35,912	128,129	-	164,041
<b>Net Position</b>	<b>\$ 269,382</b>	<b>\$ 131,989</b>	<b>\$ -</b>	<b>\$ 401,371</b>

*The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.*

# U.S. Department of Health and Human Services

## Consolidated Statement of Changes in Net Position

For the Year Ended September 30, 2015  
(in Millions)

	2015			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
<b>Cumulative Results of Operations:</b>				
Beginning Balances	\$ 227,551	\$ 6,981	\$ -	\$ 234,532
<b>Budgetary Financing Sources:</b>				
Other Adjustments (+/-)	-	(746)	-	(746)
Appropriations Used	295,986	478,803	-	774,789
Nonexchange Revenue				
Nonexchange Revenue - Tax Revenue	237,972	-	-	237,972
Nonexchange Revenue - Investment Revenue	10,854	5	-	10,859
Nonexchange Revenue - Other	3,557	-	-	3,557
Donations and Forfeitures of Cash and Cash Equivalents	75	-	-	75
Transfers-in/out without Reimbursement	(4,673)	3,467	-	(1,206)
Other (+/-)	-	(1)	-	(1)
<b>Other Financing Sources (Nonexchange):</b>				
Donations and Forfeitures of Property	-	10	-	10
Transfers-in/out Without Reimbursement (+/-)	(6)	(8)	-	(14)
Imputed Financing	30	668	(204)	494
Other (+/-)	1	841	-	842
Total Financing Sources	543,796	483,039	(204)	1,026,631
Net Cost of Operations (+/-)	549,867	480,366	(204)	1,030,029
Net Change	(6,071)	2,673	-	(3,398)
<b>Cumulative Results of Operations:</b>	\$ 221,480	\$ 9,654	\$ -	\$ 231,134
<b>Unexpended Appropriations:</b>				
Beginning Balance	\$ 16,215	\$ 107,427	\$ -	\$ 123,642
<b>Budgetary Financing Sources:</b>				
Appropriations Received	288,636	542,401	-	831,037
Appropriations Transferred in/out	-	387	-	387
Other Adjustments	21,319	(55,323)	-	(34,004)
Appropriations Used	(295,986)	(478,803)	-	(774,789)
Total Budgetary Financing Sources	13,969	8,662	-	22,631
Total Unexpended Appropriations	30,184	116,089	-	146,273
<b>Net Position</b>	<b>\$ 251,664</b>	<b>\$ 125,743</b>	<b>\$ -</b>	<b>\$ 377,407</b>

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

**U.S. Department of Health and Human Services**  
**Combined Statement of Budgetary Resources**  
For the Years Ended September 30, 2016 and 2015  
(in Millions)

	2016		2015	
	Budgetary	Non-Budgetary Credit Reform Financing Account	Budgetary	Non-Budgetary Credit Reform Financing Account
<b>Budgetary Resources</b>				
Unobligated Balance, Brought Forward, Oct 1	\$ 65,622	\$ 2	\$ 37,878	\$ 3
Recoveries of Unpaid Prior Year Obligations	36,333	-	26,380	-
Other Changes in Unobligated Balance	(3,098)	-	20,176	-
Unobligated Balance from Prior Year Budget Authority, Net	98,857	2	84,434	3
Appropriations (Discretionary and Mandatory)	1,540,233	-	1,425,607	-
Borrowing Authority (Discretionary and Mandatory)	3,720	19	-	50
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	24,844	638	32,931	80
<b>Total Budgetary Resources (Note 23)</b>	<b>\$ 1,667,654</b>	<b>\$ 659</b>	<b>\$ 1,542,972</b>	<b>\$ 133</b>
<b>Status of Budgetary Resources</b>				
New Obligations and Upward Adjustments (Notes 18, 22 and 23)	\$ 1,607,771	\$ 32	\$ 1,477,350	\$ 131
Unobligated Balance, End of Year:				
Apportioned, Unexpired Accounts	24,982	8	26,449	-
Exempt from Apportionment, Unexpired Accounts	(7,710)	-	(2,621)	-
Unapportioned, Unexpired Accounts	5,082	619	7,169	2
Unexpired Unobligated Balance, End of Year	22,354	627	30,997	2
Expired Unobligated Balance, End of Year	37,529	-	34,625	-
Unobligated Balance, End of Year	59,883	627	65,622	2
<b>Total Budgetary Resources (Note 23)</b>	<b>\$ 1,667,654</b>	<b>\$ 659</b>	<b>\$ 1,542,972</b>	<b>\$ 133</b>
<b>Change in Obligated Balance</b>				
<b>Unpaid Obligations:</b>				
Unpaid Obligations, Brought Forward, Oct 1	\$ 236,348	\$ 375	\$ 216,166	\$ 998
New Obligations and Upward Adjustments (Notes 18, 22 and 23)	1,607,771	32	1,477,350	131
Outlays (Gross)	(1,550,188)	(370)	(1,430,984)	(754)
Actual Transfers, Unpaid Obligations (Net)	-	-	196	-
Recoveries of Prior Year Unpaid Obligations	(36,333)	-	(26,380)	-
<b>Unpaid Obligations, End of Year</b>	<b>\$ 257,598</b>	<b>\$ 37</b>	<b>\$ 236,348</b>	<b>\$ 375</b>
<b>Uncollected Payments:</b>				
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	\$ (22,124)	\$ (160)	\$ (11,838)	\$ (430)
Change in Uncollected Customer Payments from Federal Sources	(4,342)	145	(10,286)	270
<b>Uncollected Payments from Federal Sources, End of Year</b>	<b>\$ (26,466)</b>	<b>\$ (15)</b>	<b>\$ (22,124)</b>	<b>\$ (160)</b>
<b>Memorandum (non-add) Entries:</b>				
Obligated Balance, Start of Year	\$ 214,224	\$ 215	\$ 204,328	\$ 568
Obligated Balance, End of Year	\$ 231,132	\$ 22	\$ 214,224	\$ 215
<b>Budget Authority and Outlays, Net:</b>				
Budget Authority, Gross (Discretionary and Mandatory)	\$ 1,568,797	\$ 657	\$ 1,458,538	\$ 130
Actual Offsetting Collections (Discretionary and Mandatory)	(22,019)	(782)	(23,260)	(350)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	(4,342)	145	(10,286)	270
Recoveries of Prior Year Paid Obligations (Discretionary and Mandatory)	513	-	-	-
<b>Budget Authority, Net (Discretionary and Mandatory)</b>	<b>\$ 1,542,949</b>	<b>\$ 20</b>	<b>\$ 1,424,992</b>	<b>\$ 50</b>
Outlays, Gross (Discretionary and Mandatory)	\$ 1,550,188	\$ 370	\$ 1,430,984	\$ 754
Actual Offsetting Collections (Discretionary and Mandatory)	(22,019)	(782)	(23,260)	(350)
Outlays, Net (Discretionary and Mandatory)	1,528,169	(412)	1,407,724	404
Distributed Offsetting Receipts	(428,128)	-	(380,187)	-
<b>Agency Outlays, Net (Discretionary and Mandatory)</b>	<b>\$ 1,100,041</b>	<b>\$ (412)</b>	<b>\$ 1,027,537</b>	<b>\$ 404</b>

*The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.*

## U.S. Department of Health and Human Services

## Statement of Social Insurance (Unaudited)

75-Year Projection as of January 1, 2016 and Prior Base Years

(in Billions)

	Estimates from Prior Years				
	2016	2015	2014	2013	2012
<i>Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 24 and 25)</i>					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	\$ 10,294	\$ 9,134	\$ 8,398	\$ 8,147	\$ 7,929
SMI Part B	19,386	17,027	17,127	15,227	14,431
SMI Part D	7,659	6,424	5,928	5,871	5,866
Have attained eligibility age (age 65 or over)					
HI	455	382	332	301	302
SMI Part B	3,660	3,300	2,873	2,620	2,395
SMI Part D	952	887	775	722	694
Those expected to become participants					
HI	9,952	8,386	7,812	7,744	7,367
SMI Part B	4,437	3,668	4,311	3,530	3,333
SMI Part D	3,602	2,845	2,609	2,617	2,568
All current and future participants					
HI	20,701	17,902	16,542	16,192	15,598
SMI Part B	27,484	23,995	24,311	21,377	20,159
SMI Part D	12,213	10,156	9,312	9,211	9,128
<i>Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 24 and 25)</i>					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	\$ 16,800	\$ 14,494	\$ 14,117	\$ 14,629	\$ 14,919
SMI Part B	19,178	16,818	17,003	15,075	14,303
SMI Part D	7,659	6,424	5,928	5,871	5,866
Have attained eligibility age (age 65 and over)					
HI	4,285	3,803	3,484	3,422	3,369
SMI Part B	4,026	3,637	3,171	2,887	2,646
SMI Part D	952	887	775	722	694
Those expected to become participants					
HI	3,437	2,791	2,764	2,913	2,891
SMI Part B	4,281	3,540	4,137	3,415	3,211
SMI Part D	3,602	2,845	2,609	2,617	2,568
All current and future participants:					
HI	24,523	21,089	20,365	20,963	21,179
SMI Part B	27,484	23,995	24,311	21,377	20,159
SMI Part D	12,213	10,156	9,312	9,211	9,128
<i>Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)</i>					
HI	\$ (3,822)	\$ (3,187)	\$ (3,823)	\$ (4,772)	\$ (5,581)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
<i>Additional Information</i>					
<i>Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)</i>					
HI	\$ (3,822)	\$ (3,187)	\$ (3,823)	\$ (4,772)	\$ (5,581)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
<i>Trust Fund assets at start of period</i>					
HI	194	197	205	220	244
SMI Part B	68	68	74	66	80
SMI Part D	1	1	1	1	1
<i>Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 24 and 25)</i>					
HI	\$ (3,628)	\$ (2,990)	\$ (3,618)	\$ (4,551)	\$ (5,337)
SMI Part B	68	68	74	66	80
SMI Part D	1	1	1	1	1

Please note for the entirety of the Statement of Social Insurance:

Totals do not necessarily equal the sum of the rounded components.

Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

**U.S. Department of Health and Human Services**  
**Statement of Social Insurance (Continued) (Unaudited)**  
 75-Year Projection as of January 1, 2016 and Prior Base Years  
 (in Billions)

	Estimates from Prior Years				
	2016	2015	2014	2013	2012
<b>Medicare Social Insurance Summary</b>					
<b>Current Participants:</b>					
<i>Actuarial present value for the 75-year projection period from or on behalf of:</i>					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	\$ 5,067	\$ 4,569	\$ 3,980	\$ 3,643	\$ 3,391
Expenditures	9,263	8,328	7,430	7,031	6,709
Income less expenditures	(4,196)	(3,759)	(3,450)	(3,388)	(3,319)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	37,339	32,585	31,453	29,244	28,227
Expenditures	43,637	37,736	37,048	35,574	35,088
Income less expenditures	(6,298)	(5,151)	(5,595)	(6,330)	(6,861)
<i>Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)</i>	(10,493)	(8,909)	(9,045)	(9,718)	(10,180)
<i>Combined Medicare Trust Fund assets at start of period</i>	263	266	280	288	325
<i>Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period</i>	(10,230)	(8,643)	(8,764)	(9,430)	(9,855)
<b>Future Participants:</b>					
<i>Actuarial present value for the 75-year projection period:</i>					
Income (excluding interest)	17,992	14,898	14,732	13,891	13,268
Expenditures	11,320	9,176	9,510	8,945	8,669
Income less expenditures	6,672	5,722	5,222	4,946	4,599
<b>Open-Group (all current and future participants):</b>					
<i>Actuarial present value of estimated future income (excluding interest) less expenditures</i>					
	(3,822)	(3,187)	(3,823)	(4,772)	(5,581)
<i>Combined Medicare Trust Fund assets at start of period</i>	263	266	280	288	325
<i>Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period</i>	\$ (3,559)	\$ (2,921)	\$ (3,542)	\$ (4,484)	\$ (5,256)

Please note for the entirety of the Statement of Social Insurance:

Totals do not necessarily equal the sum of the rounded components.

Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

**U.S. Department of Health and Human Services**  
**Statement of Changes in Social Insurance Amounts (Unaudited)**

January 1, 2015 to January 1, 2016  
Medicare Hospital and Supplementary Medical Insurance  
(in Billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
<b>Total Medicare (Note 26)</b>					
As of January 1, 2015	\$ 52,053	\$ 55,240	\$ (3,187)	\$ 266	\$ (2,921)
Reasons for change					
Change in the valuation period	2,162	2,330	(169)	2	(167)
Change in projection base	306	595	(289)	(5)	(294)
Changes in the demographic assumptions	(391)	(573)	182	-	182
Changes in economic and health care assumptions	6,501	6,867	(366)	-	(366)
Changes in law	(232)	(239)	6	-	6
Net changes	8,345	8,980	(635)	(3)	(638)
As of January 1, 2016	\$ 60,398	\$ 64,220	\$ (3,822)	\$ 263	\$ (3,559)
<b>HI - Part A (Note 26)</b>					
As of January 1, 2015	\$ 17,902	\$ 21,089	\$ (3,187)	\$ 197	\$ (2,990)
Reasons for change					
Change in the valuation period	687	855	(169)	2	(167)
Change in projection base	63	352	(289)	(6)	(294)
Changes in the demographic assumptions	63	(120)	182	-	182
Changes in economic and health care assumptions	1,987	2,353	(366)	-	(366)
Changes in law	-	(6)	6	-	6
Net changes	2,799	3,434	(635)	(4)	(638)
As of January 1, 2016	\$ 20,701	\$ 24,523	\$ (3,822)	\$ 194	\$ (3,628)
<b>SMI - Part B (Note 26)</b>					
As of January 1, 2015	\$ 23,995	\$ 23,995	\$ -	\$ 68	\$ 68
Reasons for change					
Change in the valuation period	990	990	-	-	-
Change in projection base	(113)	(113)	-	-	-
Changes in the demographic assumptions	(350)	(350)	-	-	-
Changes in economic and health care assumptions	3,183	3,183	-	-	-
Changes in law	(221)	(221)	-	-	-
Net changes	3,489	3,489	-	-	-
As of January 1, 2016	\$ 27,484	\$ 27,484	\$ -	\$ 68	\$ 68
<b>SMI - Part D (Note 26)</b>					
As of January 1, 2015	\$ 10,156	10,156	\$ -	\$ 1	\$ 1
Reasons for change					
Change in the valuation period	485	485	-	-	-
Change in projection base	356	356	-	1	1
Changes in the demographic assumptions	(103)	(103)	-	-	-
Changes in economic and health care assumptions	1,330	1,330	-	-	-
Changes in law	(11)	(11)	-	-	-
Net changes	2,057	2,057	-	-	-
As of January 1, 2016	\$ 12,213	\$ 12,213	\$ -	\$ 1	\$ 1

Totals do not necessarily equal the sum of the rounded components.

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

**U.S. Department of Health and Human Services**  
**Statement of Changes in Social Insurance Amounts (Continued)** (Unaudited)

January 1, 2014 to January 1, 2015  
Medicare Hospital and Supplementary Medical Insurance  
(in Billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
<b>Total Medicare (Note 26)</b>					
As of January 1, 2014	\$ 50,166	\$ 53,988	\$ (3,823)	\$ 280	\$ (3,542)
Reasons for change					
Change in the valuation period	2,106	2,308	(202)	(17)	(219)
Change in projection base	1,174	1,256	(82)	3	(79)
Changes in the demographic assumptions	149	184	(35)	-	(35)
Changes in economic and health care assumptions	(1,884)	(2,638)	755	-	755
Changes in law	342	142	201	-	201
Net changes	1,887	1,251	636	(14)	622
As of January 1, 2015	\$ 52,053	\$ 55,240	\$ (3,187)	\$ 266	\$ (2,921)
<b>HI - Part A (Note 26)</b>					
As of January 1, 2014	\$ 16,542	\$ 20,365	\$ (3,823)	\$ 205	\$ (3,618)
Reasons for change					
Change in the valuation period	610	812	(202)	(14)	(216)
Change in projection base	(38)	44	(82)	6	(77)
Changes in the demographic assumptions	3	38	(35)	-	(35)
Changes in economic and health care assumptions	784	30	755	-	755
Changes in law	-	(201)	201	-	201
Net changes	1,360	724	636	(8)	628
As of January 1, 2015	\$ 17,902	\$ 21,089	\$ (3,187)	\$ 197	\$ (2,990)
<b>SMI - Part B (Note 26)</b>					
As of January 1, 2014	\$ 24,311	\$ 24,311	\$ -	\$ 74	\$ 74
Reasons for change					
Change in the valuation period	1,054	1,054	-	(3)	(3)
Change in projection base	360	360	-	(3)	(3)
Changes in the demographic assumptions	82	82	-	-	-
Changes in economic and health care assumptions	(2,168)	(2,168)	-	-	-
Changes in law	356	356	-	-	-
Net changes	(316)	(316)	-	(6)	(6)
As of January 1, 2015	\$ 23,995	\$ 23,995	\$ -	\$ 68	\$ 68
<b>SMI - Part D (Note 26)</b>					
As of January 1, 2014	\$ 9,312	\$ 9,312	\$ -	\$ 1	\$ 1
Reasons for change					
Change in the valuation period	443	443	-	-	-
Change in projection base	852	852	-	-	-
Changes in the demographic assumptions	63	63	-	-	-
Changes in economic and health care assumptions	(500)	(500)	-	-	-
Changes in law	(13)	(13)	-	-	-
Net changes	844	844	-	-	-
As of January 1, 2015	\$ 10,156	\$ 10,156	\$ -	\$ 1	\$ 1

Totals do not necessarily equal the sum of the rounded components.

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

## NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

### Note 1. Summary of Significant Accounting Policies

#### A. Reporting Entity

The accompanying financial statements include activities and operations of the U.S. Department of Health and Human Services (HHS or the Department).

HHS is a Cabinet-level agency within the executive branch of the federal government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the *Department of Education Organization Act* was signed into law, creating a separate Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

#### Organization and Structure of HHS

HHS is composed of the Office of the Secretary (OS) and 11 Operating Divisions (OpDivs) with diverse missions and programs. OS and the OpDivs are each responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products and/or services. Although organizationally located within OS, the Program Support Center (PSC) is a responsibility segment and reports separately due to the business activities conducted on behalf of other federal agencies and HHS OpDivs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) for financial reporting purposes. Therefore, references to the CDC responsibility segment include ATSDR. Managers of the responsibility segments report directly to the Department's top management and the resources and results of operations can be clearly distinguished from those of other responsibility segments. The 12 responsibility segments are:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of the Secretary (OS) – excluding the Program Support Center
- Program Support Center (PSC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

Pursuant to Public Law 113-128, Section 491 of the *Workforce Innovation and Opportunity Act*, ACL received three groups of programs from the Department of Education, Office of Special Education and Rehabilitation Services. These programs include the National Institute on Disability, Independent Living and Rehabilitation Research programs; the Independent Living programs; and the Assistive Technology programs. The transfer was effective March 30, 2015.

#### B. Basis of Accounting and Presentation

HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S. Code (U.S.C.) §3515(b), the *Chief Financial Officer Act*, as



amended by the *Government Management Reform Act*, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements* (OMB Circular A-136). These statements have been prepared from HHS's financial records in conformity with accounting principles generally accepted in the U.S. The generally accepted accounting principles (GAAP) for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants as federal GAAP. Therefore, these statements are different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the use of budgetary resources.

Transactions are recorded on an accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when resources are consumed, without regard to the payment of cash. Budgetary accounting principles are designed to recognize the obligation of funds according to legal requirements, which, in many cases, is prior to the occurrence of an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of federal funds.

The financial statements consolidate the balances of approximately 250 appropriations and fund accounts. The fund accounts include accounts used for suspense, collection of receipts, and general government functions. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheets and Statements of Net Cost and Changes in Net Position. The Combined Statements of Budgetary Resources are presented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from these statements. Supplemental information is accumulated from the OpDivs' reports, regulatory reports and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

In FY 2016, changes have been made to the Statement of Budgetary Resources to reflect the new format prescribed by OMB Circular A-136.

### **C. Use of Estimates in Preparing Financial Statements**

Financial statements prepared in accordance with accounting principles generally accepted in the U.S. are based on a selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist the reader in understanding the effect of changes in assumptions on the related information.

### **D. Parent/Child Reporting**

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. HHS is party to allocation transfers with other federal entities as both a transferring (parent) entity and a receiving (child) entity. All financial activity related to these allocation transfers is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations, and budget apportionments are derived.

HHS received an exception to the parent/child reporting requirements of OMB Circular A-136, as it pertains to the allocation transfer from Department of Homeland Security to HHS for the Biodefense Countermeasures Fund for FY 2008 and beyond. Under this exception, HHS, as the child, assumed the financial statement reporting responsibilities of this fund.

Under the *Affordable Care Act*, HHS has established a child relationship with the Internal Revenue Service (IRS) of the Department of the Treasury (Treasury) for the payment of the advance premium tax credits and cost-sharing reductions to insurance providers. No financial activity is included in HHS's financial statements.

HHS also receives allocation transfers, as the child, from the Departments of Agriculture, Justice, and State. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of the Interior (DOI), Treasury, and Social Security Administration (SSA).

### E. Reclassifications and Adjustments

Certain FY 2015 balances have been reclassified to conform to FY 2016 financial statement presentations. The effects are immaterial.

### F. Funds from Dedicated Collections

Generally, funds from dedicated collections are financed by specifically identified revenues, provided to the government by non-federal sources, often supplemented by other financing sources, which remain available over time. Dedicated collections must meet the following criteria:

1. A statute committing the federal government to use specifically identified revenues and/or other financing sources that are originally provided to the federal government from a non-federal source only for designated activities, benefits, or purposes;
2. Explicit authority for the fund to retain revenues and/or other financing sources not used in the current period for future use to finance the designated activities, benefits, or purposes; and
3. A requirement to account for and report on the receipt, use, and retention of the revenues and/or other financing sources that distinguishes the dedicated collections from the federal government's general revenues.

HHS's major funds from dedicated collections are described in the sections below.

#### **Medicare Hospital Insurance (HI) Trust Fund – Part A**

Section 1817 of the *Social Security Act* established the Medicare HI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for hospital in-patient services, hospice, and select skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services as well as administrative costs, are charged to the HI Trust Fund. A portion of HHS payments to Medicare Advantage Plans is also charged to this fund. The financial statements include the HI Trust Fund activities administered by Treasury. The HI Trust Fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for the Medicare HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contributions Act (FICA)* (26 U.S.C. Ch 21) and *Self Employment Contributions Act (SECA) of 1954* (Ch 2 of Subtitle A of the Internal Revenue Code, 26 U.S.C. §1401 through §1403). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contribute the full 2.9 percent of their self-employment income. The *Social Security Act* requires the transfer of these contributions from the Treasury General Fund to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from the SSA records of wages. The SSA uses the wage totals reported by employers to the IRS via the Employer's Quarterly Federal Tax Return, as the basis for its quarterly certification of regular wages.

**Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B**

Section 1841 of the *Social Security Act* established the Medicare SMI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, ambulatory surgical centers, end-stage renal disease treatment, rural health clinics, laboratory services, and select skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services as well as administrative costs are charged to the SMI Trust Fund. A portion of HHS payments to Medicare Advantage Plans is also charged to this fund. The financial statements include SMI Trust Fund activities administered by the Treasury. The SMI Trust Fund has permanent indefinite authority.

SMI benefits and administrative expenses are generally financed by monthly premiums paid by Medicare beneficiaries and are matched by the federal government through the General Fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected and prescribes the ratio for the match as well as the method to fully compensate the Trust Fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

**Medicare SMI Trust Fund – Part D**

The *Medicare Prescription Drug, Improvement and Modernization Act* established the Medicare Prescription Drug Benefit – Part D. The program makes a prescription drug benefit available to all Medicare beneficiaries who opt into the program. Beneficiaries eligible for both Medicare and Medicaid are automatically enrolled unless they have other credible drug coverage. HHS reports the Prescription Drug Benefit within the financial statements as part of the SMI Trust Fund, in the Medicare column. Drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans, which add coverage to fee-for-service Medicare; and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. Medicare helps employers and unions continue to provide retiree drug coverage that meets Medicare’s standards through the Retiree Drug Subsidy. The Low Income Subsidy helps those with limited income and resources.

**Medicare Integrity Program**

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program and codified the Medicare Integrity Program activities previously known as “payment safeguards.” The HIPAA also established the Health Care Fraud and Abuse Control Account, which includes a dedicated appropriation for carrying out the Medicare Integrity Program. Through the Medicare Integrity Program, HHS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, and cost report audits. In addition, the Department educates providers and beneficiaries, with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI Trust Fund.

**G. Revenue and Financing Sources**

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriation and user fees. The U.S. Constitution prescribes that no money may be expended by an agency unless the funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by HHS. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

**Appropriations**

HHS receives annual, multi-year, and no-year appropriations that may be used within statutory limits. For example, funds for general operations are normally made available for one fiscal year. Funds for long-term

projects such as major construction will be available for the expected life of the project, and funds used to establish revolving fund operations are generally available indefinitely (i.e., no-year funds).

#### ***Permanent Indefinite Appropriations***

HHS permanent indefinite appropriations are open-ended; the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

#### ***Borrowing Authority***

HHS uses indefinite borrowing authority under the *Federal Credit Reform Act*, as amended, for its loan programs. Borrowing authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. Any unobligated borrowing authority does not carry forward to the next fiscal year. HHS has two programs with borrowing authority: the CMS Consumer Operated and Oriented Plan (CO-OP) Loan Program and the Health Center Loan Program.

HHS reports loans in accordance with the *Federal Credit Reform Act*. Budgetary related activity is reported separately within the Combined Statement of Budgetary Resources.

#### ***Exchange Revenue***

Exchange revenue results when HHS provides goods or services to another entity for a price and is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

HHS pricing policy for reimbursable agreements is to recover full cost and should result in no profit or loss for HHS. In addition to revenues related to reimbursable agreements, HHS collects various user fees to offset the cost of its programs. Certain fees charged by HHS are based on an amount set by law or regulation and may not represent full cost.

With minor exceptions, all revenue receipts by federal agencies are processed through the Treasury Central Accounting System. Regardless of whether they are derived from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate HHS use are deposited in the General or Special Funds of the Treasury. Amounts not retained for use by HHS are reported as Transfers-in/out Without Reimbursement to other government agencies on the HHS Consolidated Statement of Changes in Net Position.

#### ***Non-Exchange Revenue***

Non-exchange revenue results from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally-enforceable claim to resources arises, but only to the extent that collection is probable and the amount is reasonably estimable.

Non-exchange revenue is not considered to reduce the cost of the Department's operations and is separately reported on the Consolidated Statement of Changes in Net Position. Employment tax revenue collected under FICA and SECA is considered non-exchange revenue.

#### ***Imputed Financing Sources***

In certain instances, HHS's operating costs are paid out of funds appropriated to other federal entities. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management (OPM) and certain legal judgments against HHS are paid from the Judgment Fund maintained by the Treasury. When costs are identifiable to HHS, directly attributable to HHS's operations, and paid by other agencies, HHS recognizes these amounts as imputed costs within the Consolidated Statement of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

## H. Intragovernmental Transactions and Relationships

Intragovernmental transactions are business activities conducted between two different federal entities. Transactions with the public are transactions in which either the buyer or seller of the goods or services is a non-federal entity.

If a federal entity purchases goods or services from another federal entity and sells them to the public, the exchange revenue is classified as with the public, but the related costs would be classified as intragovernmental. The purpose of the classifications is to enable the federal government to provide consolidated financial statements and not to match public and intragovernmental revenue with costs incurred to produce public and intragovernmental revenue.

In the course of operations, HHS has relationships and financial transactions with numerous federal agencies including SSA and Treasury. SSA determines eligibility for Medicare programs and also deducts Medicare Part - B premiums from Social Security benefit payments for Social Security beneficiaries who elect to enroll in the Medicare Part - B program and elect to deduct their premiums from their benefit checks. SSA then transfers those funds to the Medicare Part-B Trust Fund. Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Medicare Part - D is primarily financed by the General Fund of the Treasury, as well as beneficiary premiums and payments from states.

## I. Entity and Non-Entity Assets

Entity assets are assets the reporting entity has authority to use in its operations (i.e., management has the authority to decide how the funds are used), or management is legally obligated to use the funds to meet entity obligations.

Non-entity assets are assets held by the reporting entity, but not available for use. HHS non-entity assets are composed of delinquent child support payments for the Child Support Enforcement Program, which are withheld from federal tax refunds, interest accrued on over-payments, and cost settlements reported by the Medicare contractors.

## J. Fund Balance with Treasury (FBwT)

HHS maintains its available funds with the Treasury. The FBwT is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by the Treasury. HHS FBwT accounts are reconciled with those of Treasury on a regular basis.

## K. Custodial Activity

In accordance with guidance set forth in OMB Circular A-136, HHS reports custodial activities on its Consolidated Balance Sheets. However, HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

ACF receives funding from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. FDA custodial activity involves collections of Civil Monetary Penalties assessed by the Department of Justice on behalf of the FDA. FDA is charged with assessing penalties for violations in areas such as illegally manufactured, marketed, and distributed animal food and drug products. CDC's custodial activity consists of the collection of interest on outstanding receivables and funds received from debts in collection status.

## L. Investments, Net

HHS invests entity Medicare Trust Fund balances in excess of current needs in U.S. securities. The Treasury acts as the fiscal agent for the U.S. government's investments in securities. Sections 1817 and 1841 of the *Social Security Act* require that funds in the HI and SMI Trust Funds not necessary to meet current expenditures be invested in interest-bearing obligations or in obligations guaranteed as to both principal and interest by the U.S. government. The cash receipts, collected from the public as dedicated collections, are deposited with the Treasury, which uses the cash for general governmental purposes. Treasury securities are issued by the Bureau of the Fiscal Service to the HI and SMI Trust Funds as evidence of their receipt and are reported as an asset for the Trust Funds and a corresponding liability of the Treasury. The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI Trust Funds.

The Treasury securities provide the HI and SMI Trust Funds with authority to draw upon the U.S. Treasury to make future benefit payments or other expenditures. When the Trust Funds require redemption of these securities to make expenditures, the government finances the expenditures by raising taxes, raising other receipts, borrowing from the public or repaying less debt, or curtailing other expenditures. This is the same way that the government finances all expenditures.

The Treasury securities issued and redeemed to the HI and SMI Trust Funds are Non-Marketable (Par Value) securities. These investments are carried at face value as determined by Treasury. Interest income is compounded semi-annually (i.e., June and December) by Treasury; and at fiscal year-end, interest income is adjusted to include an accrual for interest earned from July 1 to September 30 (See Note 4).

The Vaccine Injury Compensation Trust Fund, a dedicated collections fund similar to the HI and SMI Trust Funds, invests in Non-Marketable, Market-Based securities issued by the Bureau of the Fiscal Service in the form of One Day Certificates and Market-Based Bills, Notes, and Bonds.

The NIH Gift Funds are invested in Non-Marketable, Market-Based Securities issued by the Bureau of the Fiscal Service. Funds are invested for either a 90 or 180-day period based on the need for funds. No provision is made for unrealized gains or losses on these securities, since it is HHS's intent to hold investments to maturity.

The *Children's Health Insurance Program Reauthorization Act* established a Child Enrollment Contingency Fund to provide additional funding to states that experience shortfalls in their Children's Health Insurance Programs (CHIP). The *Affordable Care Act* extended the availability of the fund through 2015, and MACRA extended the fund for an additional 2 years, through 2017. This fund is invested in Non-Marketable, Market-Based Bills issued by the Bureau of the Fiscal Service. These investments will be redeemed as funds are needed by the states to cover short-term shortfalls in the program.

## M. Accounts Receivable, Net

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible amounts on public receivables. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for reimbursable work. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible. Accounts Receivable, Net from the public is primarily composed of provider and beneficiary over-payments: Medicare Prescription Drug over-payments, Medicare premiums, civil monetary penalties and other restitutions, state phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, and the recognition of Medicare Secondary Payer accounts receivable.

Accounts Receivable, Net from the public is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts

receivable, HHS calculates the allowance for uncollectible amounts based on the collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the preceding 5 years. The Medicaid accounts receivable have been recorded at a net realizable amount based on historical analyses of actual recoveries and the rate of disallowances found in favor of the states. Other accounts receivable have been recorded to account for amounts due from Marketplace activities.

## **N. Advances and Accrued Grant Liability**

HHS awards grants to various grantees and provides advance payments to meet grantees' cash needs in carrying out HHS programs. Advance payments are liquidated upon grantees reporting expenditures on the quarterly *Federal Financial Report*. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the Advances account to a negative balance. An Accrued Grant Liability occurs when the accrued grant expenses exceed outstanding advances to grantees.

HHS grants are classified into two categories: Grants Not Subject to Grant Expense Accrual and Grants Subject to Grant Expense Accrual. Grants Not Subject to Grant Expense Accrual represents formula grants, commonly referred to as block grants, under which grantees provide a variety of services or payments to individuals and local agencies. Expenses are recorded as the grantees draw funds. These grants are funded based on allocations determined by budgets and agreements approved by the sponsoring OpDiv.

For Grants Subject to Grant Expense Accrual, commonly referred to as non-block grants, grantees draw funds based on their estimated cash needs. As grantees report their actual disbursements quarterly, the amounts are recorded as expenses and their advance balances are reduced. At year-end, the OpDivs report both actual payments made through the fourth quarter and an unreported grant expenditure estimate for the fourth quarter based on historical spending patterns of the grantees.

## **O. Inventory and Related Property, Net**

Inventory and Related Property, Net primarily consists of Inventory Held for Sale, Operating Materials and Supplies, and Stockpile Materials.

Inventory Held for Sale consists of small equipment and supplies held by the Service and Supply Funds (SSF) for sale to HHS components and other federal entities. Inventories Held for Sale are valued at historical cost using the weighted average valuation method for the PSC's SSF inventories and using the moving average valuation method for the NIH's SSF inventories.

Operating Materials and Supplies include pharmaceuticals, biological products, and other medical supplies used to provide medical services and conduct medical research. They are recorded as assets when purchased and are expensed when consumed. Operating Materials and Supplies are valued at historical cost using the first-in/first-out (FIFO) cost flow assumption.

Stockpile Materials are held in reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Vaccines for Children (VFC) and Avian Influenza (H5N1). The H5N1 vaccine stockpile is held in reserve to respond to an avian flu pandemic declaration. The stockpile contains several million doses of vaccine in bulk which are stored and maintained for possible use.

Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulin antitoxins, and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC and H5N1.



## P. General Property, Plant and Equipment, Net

The General Property, Plant, and Equipment, Net consists of buildings, structures, and facilities used for general operations, land acquired for general operating purposes, equipment, assets under capital lease, leasehold improvements, construction-in-progress; and internal use software. The basis for recording purchased Property, Plant and Equipment is full cost, including all costs incurred to bring the Property, Plant, and Equipment to a form and location suitable for its intended use and is presented net of accumulated depreciation.

The cost of Property, Plant, and Equipment acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. When property is acquired through a donation, the cost recognized is the estimated fair market value on the date of acquisition. The cost of Property, Plant and Equipment transferred from other federal entities is the transferring entity's net book value. Except for internal use software, HHS capitalizes all Property, Plant, and Equipment with an initial acquisition cost of \$25,000 or more and an estimated useful life of 2 years or more.

HHS has commitments under various operating leases with private entities as well as the General Services Administration (GSA) for offices, laboratory space, and land. Leases with private entities have initial or remaining non-cancelable lease terms from 1 to 50 years; however, GSA leases are cancelable with 120 days' notice. Under an operating lease, the cost of the lease is expensed as incurred.

Property, Plant and Equipment is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

In accordance with Statement of Federal Financial Accounting Standards (SFFAS) Number 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS's capitalization threshold for internal use software costs for appropriated fund accounts is \$1 million and the threshold for revolving fund accounts is \$500 thousand. Costs below the threshold levels are expensed. Software is amortized using the straight line method over a period of 5 to 10 years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

## Q. Stewardship Land

HHS stewardship land (i.e., land not acquired for or in connection with general property, plant, and equipment) is Indian Trust land used to support the IHS day-to-day operations of providing health care to American Indians and Alaskan Natives in remote areas of the country where no other facilities exist. In accordance with SFFAS Number 29, *Heritage Assets and Stewardship Land*, HHS does not report a related amount on the Balance Sheet.

HHS asset accountability reports differentiate Indian Trust land parcels from General Property, Plant and Equipment situated thereon.

## R. Liabilities

Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare HI Trust Fund, since liabilities are only those items that are present obligations of the



government. HHS's liabilities are classified as covered by budgetary resources or not covered by budgetary resources.

#### ***Liabilities Covered by Budgetary Resources***

Available budgetary resources include new budget authority, spending authority from offsetting collections, recoveries of expired budget authority, unobligated balances of budgetary resources at the beginning of the year, permanent indefinite appropriation, and borrowing authority.

#### ***Liabilities Not Covered by Budgetary Resources***

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include contingencies, employee annual leave earned, but not taken, and amounts billed by the Department of Labor (DOL) for disability payments. The actuarial FECA liability determined by the DOL but not yet billed is also included in this category.

### **S. Accounts Payable**

Accounts Payable primarily consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

### **T. Accrued Payroll and Benefits**

Accrued Payroll and Benefits consists of salaries, wages, leave, and benefits earned by employees but not disbursed at the end of the reporting period. A liability for annual and other vested compensatory leave is accrued as earned and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability, since it will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consists primarily of HHS's current FECA liability to DOL.

### **U. Entitlement Benefits Due and Payable**

Entitlement Benefits Due and Payable represents a liability for Medicare, Medicaid and CHIP owed to the public for medical services Incurred But Not Reported (IBNR) as of the end of the reporting period. The Medicare and Medicaid programs are the largest entitlement programs in HHS.

#### ***Medicare***

The Medicare liability is developed by the CMS Office of the Actuary and includes:

- An estimate of claims incurred that may or may not have been submitted to the Medicare contractors, but not yet approved for payment;
- Actual claims approved for payment by the Medicare contractors for which checks have not yet been issued;
- Checks issued by the Medicare contractors in payment of claims that have not yet been cashed by payees;
- Periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year;
- An estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

HHS develops estimates for medical costs IBNR using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, medical care professional contract rate changes, medical care consumption, and other

medical cost trends. HHS estimates liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, HHS re-examines previously established medical cost payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, HHS adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, HHS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

#### ***Medicaid and CHIP***

The Medicaid and CHIP estimates represent the net federal share of expenses incurred by the states but not yet reported to HHS. This estimate is developed based on historical relationships between prior net payables to the states and current activity.

### **V. Federal Employee and Veterans' Benefits**

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory benefit plan, for its active duty officers, retiree annuitants and survivors. The plan does not have accumulated assets and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. HHS records the present value of the Commissioned Corps pension and post-retirement health benefits.

The liability for federal employee and veterans' benefits also includes an actuarial liability for estimated future payments for workers' compensation pursuant to the FECA. FECA provides income and medical cost protection to federal employees who are injured on the job or who sustained a work-related occupational disease. It also covers beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by DOL, which pays valid claims and subsequently bills the employing federal agency. The FECA liability consists of two components: (1) actual claims billed by the DOL to agencies but not yet paid; and (2) an estimated liability for future benefit payments as a result of past events such as death, disability, and medical costs. The claims that have been billed by DOL are included in Accrued Payroll and Benefits.

Most HHS employees participate in the Civil Service Retirement System (CSRS), a defined benefit plan, or the Federal Employees Retirement System (FERS), a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. The FERS plan has 3 parts: a defined benefit payment, Social Security benefits, and the Thrift Savings Plan. For employees covered under FERS, HHS contributes a fixed percentage of pay for the defined benefit portion and the employer's matching share for Social Security and Medicare Insurance. HHS automatically contributes 1 percent of each employee's pay to the Thrift Savings Plan and matches the first 3 percent of employee contributions dollar for dollar. Each additional dollar of the employee's next 2 percent of basic pay is matched at 50 cents on the dollar.

OPM is the administering agency for both of these benefit plans and, thus, reports CSRS and FERS assets, accumulated plan benefits, and unfunded liabilities applicable to federal employees. Therefore, HHS does not recognize any liability on its Consolidated Balance Sheets for pensions, other retirement benefits, or other post-employment benefits of its federal employees with the exception of the PHS Commissioned Corps. However, HHS does recognize an expense in the Consolidated Statement of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

## W. Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to HHS. The uncertainty ultimately should be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS Number 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS Number 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities.

HHS and its components could be parties to various administrative proceedings, legal actions, and claims brought by or against it. With the exception of pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur, and the related future outflow or sacrifice of resources is measurable. For pending, threatened, or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur and the related future outflow or sacrifice of resources is measurable.

HHS has no material obligations related to cancelled appropriations for which there is a contractual commitment for payment or for contractual arrangements which many require future financial obligations.

## X. Statement of Social Insurance

The Statement of Social Insurance presents the projected 75-year actuarial present values of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-specific conditions. The projected potential future income and expenditures under current law are not included in the accompanying Consolidated Balance Sheets, Statements of Net Cost, and Changes in Net Position or Combined Statement of Budgetary Resources.

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. The projections in this report (with one exception related to depletion of the HI Trust Fund), are based on current law; that is, they assume that laws on the books will be implemented and adhered to with respect to scheduled taxes, premium revenues, and payments to providers and health plans. The estimates depend on many economic, demographic, and health care-specific assumptions. These include changes in per beneficiary health care cost, wages, the gross domestic product (GDP), the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The assumptions underlying the Statement of Social Insurance actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2016*. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

## **Y. Affordable Care Act**

In FY 2010, President Barack Obama signed health insurance reform legislation giving Americans more control over their health care. The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* collectively referred to as the *Affordable Care Act* ensures that all Americans have access to quality, affordable health care, while helping to reduce health care costs. Further information is available at [www.healthcare.gov](http://www.healthcare.gov).

The *Affordable Care Act* contains the most significant changes to health care coverage since passage of the *Social Security Act*. The *Affordable Care Act* provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). The programs under CCIIO include: Health Insurance Marketplaces (the “Marketplace”) and the CO-OP program. A brief description of these programs and their impact on the financial statement is presented below.

### ***Health Insurance Marketplaces and the Basic Health Program***

Grants have been provided to the States to establish Health Insurance Marketplaces. The initial grants were made by the HHS to the States “not later than one (1) year after the date of enactment.” Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS through December 31, 2014, after which time no further grants could be made. All Marketplaces were launched on October 1, 2013.

To help make health insurance more affordable to consumers, HHS makes payments of advance premium tax credits (APTC) and cost-sharing reductions (CSR) to health insurance issuers on behalf of consumers who are eligible for financial assistance. States may also opt to cover some Marketplace-eligible individuals through the Basic Health Program (BHP), and a state that operates a BHP receives federal funding equal to 95 percent of the amount of the premium tax credits and CSRs that would have otherwise been provided to (or on behalf of) eligible individuals if those individuals enrolled in Qualified Health Plans through the Marketplace. APTC, CSR, and BHP payments (which are included in the IRS financial statements; see Note 1-D) are a critical component of the Marketplace, and \$42 billion has been allocated for these payments. In addition to these payments on behalf of consumers, HHS collects Marketplace user fees from issuers participating in the Federally-facilitated Marketplace.

### ***Consumer Operated and Oriented Plan Program***

The CO-OP Program fosters qualified non-profit health insurance issuers created to offer qualified health plans to the individual and small group markets. Under this program, HHS provides assistance to organizations applying to become qualified non-profit health insurance issuers through loans to assist in meeting start-up costs and to assist the applicant meet state solvency requirements. In accordance with regulations as well as legislative requirements, start-up loans shall be repaid within 5 years and the solvency loans within 15 years after disbursement, considering state reserve requirements and solvency regulations.

### ***Transitional Reinsurance Program***

The Transitional Reinsurance Program was established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016. All health insurance issuers and third party administrators, on behalf of self-insured group health plans, must make contributions to support reinsurance payments that cover high-cost individuals in non-grandfathered plans in the individual market, inside and outside the Marketplace. The Transitional Reinsurance Program is a critical element in helping to ensure a stabilized individual market in the initial years of the implementation of the *Affordable Care Act*’s insurance market reforms.

***Risk Adjustment Program***

The Risk Adjustment Program is a permanent program. It applies to non-grandfathered individuals and small group plans inside and outside the Marketplaces. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. States may operate risk adjustment programs; CMS will operate a risk adjustment program for each state that does not operate its own. In 2015 and 2016, Massachusetts is the only state that operated its own risk adjustment program.

***Risk Corridor Program***

The temporary Risk Corridors Program will operate during the years 2014 through 2016. This program applies to qualified health plans in the individual and small group markets, inside and outside the Marketplaces and protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between CMS and qualified health plans to help ensure stable health insurance premiums.

**Note 2. Entity and Non-Entity Assets** (in Millions)

	2016	2015
Non-Entity Intragovernmental Assets		
Fund Balance with Treasury	\$ -	\$ 8
Accounts Receivable	5	3
Total Non-Entity Intragovernmental Assets	5	11
Accounts Receivable With the Public	37	27
Total Non-Entity Assets	42	38
Total Entity Assets	562,611	528,757
<b>Total Assets</b>	<b>\$ 562,653</b>	<b>\$ 528,795</b>

**Note 3. Fund Balance with Treasury** (in Millions)

	2016	2015
Fund Balance with Treasury		
Trust Funds	\$ 54,050	\$ 45,056
Revolving Funds	2,443	1,433
Appropriated Funds	172,984	170,155
Special Funds and Other Funds	8,282	2,815
<b>Total</b>	<b>\$ 237,759</b>	<b>\$ 219,459</b>
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	\$ 17,280	\$ 23,828
Unavailable	43,230	41,796
Obligated Balance not yet Disbursed	231,154	214,439
Non-Budgetary Fund Balance with Treasury	(53,905)	(60,604)
<b>Total</b>	<b>\$ 237,759</b>	<b>\$ 219,459</b>

The FBwT are funds primarily available to pay current expenditures and liabilities. Special Funds includes the CHIP Child Enrollment Contingency of \$5.4 billion and *Affordable Care Act* Risk Programs of \$2.2 billion. Other Funds includes balances in deposit funds, management funds and related non-spending accounts. The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of \$8.8 billion and \$14.5 billion as of September 30, 2016 and September 30, 2015, respectively. The restricted amount is primarily for the *Affordable Care Act* programs, CHIP, CMS Program Management, and State Grants and Demonstrations.

**Note 4. Investments, Net** (in Millions)

	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
<b>2016</b>					
Intragovernmental Securities					
Non-Marketable: Par Value	\$ 255,545	\$ -	\$ 2,256	\$ 257,801	\$ 257,801
Non-Marketable: Market-Based	4,446	(195)	25	4,276	4,276
<b>Total, Intragovernmental</b>	<b>\$ 259,991</b>	<b>\$ (195)</b>	<b>\$ 2,281</b>	<b>\$ 262,077</b>	<b>\$ 262,077</b>
<b>2015</b>					
Intragovernmental Securities					
Non-Marketable: Par Value	\$ 261,585	\$ -	\$ 2,408	\$ 263,993	\$ 263,993
Non-Marketable: Market-Based	5,825	(194)	27	5,658	5,658
<b>Total, Intragovernmental</b>	<b>\$ 267,410</b>	<b>\$ (194)</b>	<b>\$ 2,435</b>	<b>\$ 269,651</b>	<b>\$ 269,651</b>

HHS investments consist primarily of Medicare Trust Fund (i.e., funds from dedicated collections) investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2017 through June 30, 2031 with interest rates ranging from 1.875 percent to 5.25 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2017 with an interest rate from 1.625 percent to 1.875 percent.

Securities held by the Vaccine Injury Compensation Trust Fund (i.e., funds from dedicated collections) will mature in FY 2017 through FY 2021. The Market-Based Notes paid from 1.0 percent to 3.875 percent during October 1, 2015 to September 30, 2016 and 1.0 percent to 3.875 percent during October 1, 2014 to September 30, 2015. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market Based Bills held in the NIH gift funds held during 12 months of FY 2016, yielded from 0.0050 percent to 0.5163 percent depending on date purchased and length of time to maturity.

The investments held by the CHIP Child Enrollment Contingency Fund in the amount of \$0.6 billion as of September 30, 2016, are short term Non-Marketable Market-Based Bills purchased at a discount which are fully amortized at the maturity date.

**Note 5. Accounts Receivable, Net** (in Millions)

<u>2016</u>	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
<i>Intragovernmental</i>					
Entity	\$ 1,007	\$ -	\$ 1,007	\$ -	\$ 1,007
Non-Entity	5	-	5	-	5
<b>Total, Intragovernmental</b>	<b>\$ 1,012</b>	<b>\$ -</b>	<b>\$ 1,012</b>	<b>\$ -</b>	<b>\$ 1,012</b>
<i>With the Public</i>					
Entity					
Medicare	\$ 10,193	\$ -	\$ 10,193	\$ (2,740)	\$ 7,453
Medicaid	8,382	-	8,382	(1,186)	7,196
Other	9,722	278	10,000	(483)	9,517
Non-Entity	3	58	61	(24)	37
<b>Total With the Public</b>	<b>\$ 28,300</b>	<b>\$ 336</b>	<b>\$ 28,636</b>	<b>\$ (4,433)</b>	<b>\$ 24,203</b>

<u>2015</u>	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
<i>Intragovernmental</i>					
Entity	\$ 1,002	\$ -	\$ 1,002	\$ -	\$ 1,002
Non-Entity	3	-	3	-	3
<b>Total, Intragovernmental</b>	<b>\$ 1,005</b>	<b>\$ -</b>	<b>\$ 1,005</b>	<b>\$ -</b>	<b>\$ 1,005</b>
<i>With the Public</i>					
Entity					
Medicare	\$ 8,806	\$ -	\$ 8,806	\$ (2,031)	\$ 6,775
Other	16,713	269	16,982	(1,869)	15,113
Non-Entity	-	53	53	(26)	27
<b>Total With the Public</b>	<b>\$ 25,519</b>	<b>\$ 322</b>	<b>\$ 25,841</b>	<b>\$ (3,926)</b>	<b>\$ 21,915</b>

As of September 30, 2016, the other accounts receivable with the public is primarily related to collections for Marketplace activities.



**Note 6. Inventory and Related Property, Net** (in Millions)

	2016	2015
Inventory Held for Current Sale, Net	\$ 7	\$ 7
Operating Materials and Supplies Held for Use	68	73
Stockpile Materials Held for Emergency or Contingency	9,324	9,436
<b>Inventory and Related Property, Net</b>	<b>\$ 9,399</b>	<b>\$ 9,516</b>

**Note 7. General Property, Plant and Equipment, Net** (in Millions)

			2016		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	\$ 54	\$ -	\$ 54
Construction in Progress	-	-	772	-	772
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,980	(2,919)	3,061
Equipment	Straight Line	3-20 Yrs	2,029	(1,208)	821
Internal Use Software	Straight Line	5-10 Yrs	1,998	(1,132)	866
Assets Under Capital Lease	Straight Line	1-30 Yrs	139	(63)	76
Leasehold Improvements	Straight Line	*Life of Lease	52	(37)	15
<b>Totals</b>			<b>\$ 11,024</b>	<b>\$ (5,359)</b>	<b>\$ 5,665</b>

			2015		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	\$ 53	\$ -	\$ 53
Construction in Progress	-	-	650	-	650
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	6,140	(2,788)	3,352
Equipment	Straight Line	3-20 Yrs	1,922	(1,134)	788
Internal Use Software	Straight Line	5-10 Yrs	1,955	(965)	990
Assets Under Capital Lease	Straight Line	1-30 Yrs	126	(59)	67
Leasehold Improvements	Straight Line	*Life of Lease	51	(34)	17
<b>Totals</b>			<b>\$ 10,897</b>	<b>\$ (4,980)</b>	<b>\$ 5,917</b>

\*7 to 15 years or the life of the lease, whichever is shorter.

**Note 8. Advances** (in Millions)

	2016	2015
<i>Intragovernmental</i>		
Advances to Other Federal Entities	\$ 239	\$ 178
<i>With the Public</i>		
Travel Advances & Emergency Employee Salary Advances	2	5
Other Prepayments & Deferred Charges	18	28
Prescription Drug and Medicare Advantage	21,460	-
<b>Total With the Public</b>	<b>\$ 21,480</b>	<b>\$ 33</b>

As of September 30, 2016, advances with the public primarily represent payment of the Prescription Drug and Medicare Advantage benefit payments for October 2016 that occurred on September 30 instead of October 1.

**Note 9. Liabilities Not Covered by Budgetary Resources** (in Millions)

	2016	2015
<i>Intragovernmental</i>		
Accrued Payroll and Benefits	\$ 59	\$ 58
Other	4,867	1,699
<b>Total Intragovernmental</b>	<b>\$ 4,926</b>	<b>\$ 1,757</b>
Federal Employee and Veterans' Benefits (Note 11)	12,892	12,072
Accrued Payroll and Benefits	650	632
Contingencies and Commitments (Note 14)	12,394	9,105
Accrued Liabilities (Note 12)	14,420	14,250
Other	210	(1,512)
<b>Total Liabilities Not Covered by Budgetary Resources</b>	<b>\$ 45,492</b>	<b>\$ 36,304</b>
<b>Total Liabilities Covered by Budgetary Resources</b>	<b>115,790</b>	<b>115,084</b>
<b>Total Liabilities</b>	<b>\$ 161,282</b>	<b>\$ 151,388</b>

The *Bipartisan Budget Act of 2015* (Section 601) authorized a transfer from the General Fund to SMI, to temporarily replace the reduction in Medicare Part B premiums. Section 601 created an "additional premium" charged alongside the normal Medicare Part B monthly premiums, beginning in 2016, which will be used to pay back the General Fund transfer without interest. As of September 30, 2016, \$3,289 million is still owed and reported under Other Liabilities.

**Note 10. Entitlement Benefits Due and Payable** (in Millions)

	2016	2015
Medicare Fee-For-Service	\$ 44,866	\$ 45,268
Medicare Advantage/Prescription Drug Program	19,045	20,953
Medicaid	35,419	36,758
CHIP	978	773
Other	7,922	4,397
<b>Totals</b>	<b>\$ 108,230</b>	<b>\$ 108,149</b>

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage and Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

The Medicare fee-for-service liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment; (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued; (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees; (d) periodic interim payments for services rendered in the current FY but paid in the subsequent FY; and (e) an estimate of retroactive settlements of cost reports. The September 30, 2016 and 2015 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2016. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2016.

The Medicaid and CHIP estimates represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS.

The Other Liability line item includes estimates of payments due to those participating in Marketplace activities.

#### **Note 11. Federal Employee and Veterans' Benefits** (in Millions)

	2016	2015
<i>With the Public</i>		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	\$ 11,995	\$ 11,227
PHS Commissioned Corp Post-Retirement Health Benefits	625	574
Workers' Compensation Benefits (Actuarial FECA Liability)	272	271
<b>Total, Federal Employee and Veterans' Benefits</b>	<b>\$ 12,892</b>	<b>\$ 12,072</b>

#### **Public Health Service (PHS) Commissioned Corps**

HHS administers the PHS Commissioned Corps Retirement System for 6,583 active duty officers and 6,734 retiree annuitants and survivors. As of September 30, 2016, the actuarial accrued liability for the retirement benefit plan was \$12.0 billion and \$0.6 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commission Corp Retirement System and Post-Retirement Health Benefits are not funded. Therefore, in accordance with SFFAS Number 33, *Pensions, Other Retirement Benefits and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates* (SFFAS Number 33), the discount rate should be based on long-term assumptions, for marketable securities (i.e., Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates should be matched with the expected timing of the associated expected cashflow. A single discount

## NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

rate may be used for all the projected cashflow, as long as the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2016 and September 30, 2015, were:

	2016	2015
Discount rate	4.26 percent	4.44 percent
Annual basic pay scale increase	2.51 percent	2.68 percent
Annual inflation	2.01 percent	2.18 percent

	2016	2015
Beginning Liability Balance	\$ 11,801	\$ 11,691
Expense		
Normal Cost	326	321
Interest on the liability balance	493	508
Actuarial (Gain)/Loss		
From experience	107	(98)
From assumption changes		
Change in discount rate assumption	303	326
Change in inflation/salary increase assumption	(259)	(508)
Change in mortality rate/others	332	31
Net Actuarial (Gain)/Loss	483	(249)
Total expense	\$ 1,302	\$ 580
Less amounts paid	(483)	(470)
Ending Liability Balance	\$ 12,620	\$ 11,801

The following shows key valuation results as of September 30, 2016 and 2015, in conformance with the actuarial reporting standards set forth in the SFFAS Number 5, *Accounting for Liabilities of the Federal Government* and SFFAS Number 33. The valuation is based upon the current plan provisions, membership data collected as of June 30, 2016, and actuarial assumptions. The September 30, 2016 valuation includes an increase in liabilities of \$819 million resulting from an increase in normal cost and an actuarial loss from changes in assumptions and experience. Volatility of the discount rate significantly affects the liabilities for these benefits. Therefore, to mitigate the impact of this volatility, SFFAS Number 33 also provides for the use of historical average rates to prevent the undue influence of current or near term rates.

### Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. In FY 2015, the fund effected a change in accounting estimate to refine the methodology used for selecting the interest rate assumptions and enhance matching between the timing of cash flows and interest rates. For FY 2016, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues (the TNC Yield Curve) for the current and prior 4 years for FY 2016 and FY 2015, respectively. Interest rate assumptions utilized for discounting as of September 30, 2016 and September 30, 2015 follow.

# NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

	2016	2015
Wage Benefits	2.781% in Year 1 and years thereafter	3.134% in Year 1 and years thereafter
Medical Benefits	2.261% in Year 1 and years thereafter	2.496% in Year 1 and years thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors (i.e., cost of living adjustments [COLA]) and medical inflation factors (i.e., consumer price index-medical [CPIM]) are applied to the calculations of projected future benefits. These factors are also used to adjust historical payments to current year constant dollars. The compensation COLAs and CPIMs used in the projections are:

FY	COLA	CPIM
2016	N/A	N/A
2017	1.31%	2.99%
2018	1.13%	3.09%
2019	1.23%	3.40%
2020	1.45%	3.68%
2021	1.85%	3.87%

## Note 12. Accrued Liabilities (in Millions)

	2016	2015
Grant Liability	\$ 4,915	\$ 3,831
Other Accrued Liabilities	9,505	10,419
Accrued Liabilities	<u>\$ 14,420</u>	<u>\$ 14,250</u>

## Note 13. Other Liabilities (in Millions)

	2016		2015	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	\$ 136	\$ 960	\$ 118	\$ 969
Advances from Others	609	744	446	720
Deferred Revenue	-	1,066	-	642
Custodial Liabilities	407	5	729	12
Contingent Liabilities (Note 14)	1,021	-	941	-
Other	4,890 <sup>8</sup>	2,188	1,375	977
Total Other Liabilities	<u>\$ 7,063</u>	<u>\$ 4,963</u>	<u>\$ 3,609</u>	<u>\$ 3,320</u>

<sup>8</sup> Please refer to Note 9 - Liabilities Not Covered By Budgetary Resources for details.

## Note 14. Contingencies and Commitments

HHS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the federal government. HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible and an estimate can be determined or an estimate of the range of possible liability has been determined. Selected contingencies and commitments are described below.

### ***Medicaid Audit and Program Disallowances***

The Medicaid amount of \$10.2 billion (\$7.5 billion in FY 2015) consists of Medicaid audit and program disallowances of \$2.8 billion (\$2.4 billion in FY 2015) and of \$7.4 billion (\$5.1 billion in FY 2015) for reimbursement of State Plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. The funds could have been returned or HHS can decrease the state's authority. HHS will be required to pay these amounts if the appeals are decided in favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made.

### ***Appeals at the Provider Reimbursement Review Board***

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability. As of September 30, 2016, 10,005 cases (9,737 in FY 2015) remain on appeal. A total of 2,515 new cases (3,473 in FY 2015) were filed and 10 cases were reopened (9 in FY 2015). The PRRB rendered decisions on 66 cases (84 in FY 2015) and 2,191 additional cases (2,972 in FY 2015) were dismissed, withdrawn, or settled prior to an appeal hearing. The PRRB receives no information on the value of these cases that are settled prior to a hearing.

### ***Other Accrued Contingent Liabilities***

The U.S. Supreme Court decision in *Salazar v. Ramah Navajo Chapter*, dated June 18, 2012, is likely to result in increased claims against the IHS. As a result of this decision, many tribes have filed claims. Some claims have been paid and others have been asserted but not yet settled. It is expected that some tribes will file additional claims for prior years. An estimated loss related to this matter was accrued last year and the remaining unpaid accrued liability is included on the Consolidated Balance Sheet.

The Vaccine Injury Compensation Program is administered by HRSA and provides compensation for vaccine-related injury or death. A contingent liability has been accrued in the financial statements for the estimated future payment value of injury claims.

**Note 15. Revenue** (in Millions)**2016 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification**

	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
<i>Intragovernmental</i>							
Gross Cost	\$ 119	\$ 6,275	\$ 840	\$ 73	\$ 7,307	\$ (2,338)	\$ 4,969
Exchange Revenue	(17)	(2,973)	(12)	(7)	(3,009)	2,044	(965)
Net Cost, <i>Intragovernmental</i>	102	3,302	828	66	4,298	(294)	4,004
<i>With the Public</i>							
Gross Cost	14,823	467,160	646,201	38,643	1,166,827	-	1,166,827
Exchange Revenue	-	(15,113)	(80,915)	(31)	(96,059)	-	(96,059)
Net Cost, <i>With the Public</i>	14,823	452,047	565,286	38,612	1,070,768	-	1,070,768
Total Gross Cost	14,942	473,435	647,041	38,716	1,174,134	(2,338)	1,171,796
Total Exchange Revenue	(17)	(18,086)	(80,927)	(38)	(99,068)	2,044	(97,024)
Total Net Cost of Operations	\$ 14,925	\$ 455,349	\$ 566,114	\$ 38,678	\$ 1,075,066	\$ (294)	\$ 1,074,772

**2015 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification**

	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
<i>Intragovernmental</i>							
Gross Cost	\$ 122	\$ 6,517	\$ 1,026	\$ 20	\$ 7,685	\$ (2,548)	\$ 5,137
Exchange Revenue	(33)	(3,116)	(12)	(7)	(3,168)	2,344	(824)
Net Cost, <i>Intragovernmental</i>	89	3,401	1,014	13	4,517	(204)	4,313
<i>With the Public</i>							
Gross Cost	13,978	453,400	621,810	38,002	1,127,190	-	1,127,190
Exchange Revenue	-	(25,769)	(75,689)	(16)	(101,474)	-	(101,474)
Net Cost, <i>With the Public</i>	13,978	427,631	546,121	37,986	1,025,716	-	1,025,716
Total Gross Cost	14,100	459,917	622,836	38,022	1,134,875	(2,548)	1,132,327
Total Exchange Revenue	(33)	(28,885)	(75,701)	(23)	(104,642)	2,344	(102,298)
Total Net Cost of Operations	\$ 14,067	\$ 431,032	\$ 547,135	\$ 37,999	\$ 1,030,233	\$ (204)	\$ 1,030,029

**Exchange Revenue**

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was \$97.0 billion and \$102.3 billion through September 30, 2016 and 2015, respectively. HHS's exchange revenue consists primarily of Medicare premiums collected from beneficiaries. HHS also charges user fees and collects revenues related to reimbursable agreements with other government entities.

**Note 16. Legal Arrangements Affecting Use of Unobligated Balances**

The unobligated balances on the Combined Statement of Budgetary Resources consist of Trust Funds, appropriated funds, revolving funds, management funds, gift funds, Cooperative Research and Development Agreement funds, and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for 5 subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All Trust Fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of Trust Fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Combined Statement of Budgetary Resources; therefore, it is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the Trust Funds and become available for obligation, as needed. The entire Trust Fund balances in the amount of \$201.6 billion, as of September 30, 2016, (\$201.1 billion as of September 30, 2015), are included in Investments on the Consolidated Balance Sheets.

**Exempt from Apportionment**

This amount includes the FY 2016 recording of obligations required by law, where such obligations are in excess of available funding. These obligations were incurred by operation of law; thus, they are reflected as exempt from apportionment. The *Anti-Deficiency Act* has not been violated, as “[t]he prohibitions contained in the *Anti-Deficiency Act* are directed at discretionary obligations entered into by administrative officers.” B-219161 (Oct. 2, 1985).

**Note 17. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)**

	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Outlays, net (total) (discretionary and mandatory)
2015				
Combined Statement of Budgetary Resources	\$ 1,543,105	\$ 1,477,481	\$ 380,187	\$ 1,408,128
Expired Accounts	(35,401)	2	-	-
Other	(334)	(545)	43	67
Budget of the U.S. Government	<u>\$ 1,507,370</u>	<u>\$ 1,476,938</u>	<u>\$ 380,230</u>	<u>\$ 1,408,195</u>

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2016, has not been published, therefore, no comparisons can be made between FY 2016 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2018 President's Budget* is expected to be released in February 2017 and may be obtained from OMB's website, [www.whitehouse.gov/omb/budget](http://www.whitehouse.gov/omb/budget), or from Government Publishing Office's website, [www.gpo.gov](http://www.gpo.gov).

HHS reconciled the amounts of the FY 2015 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2015 from the Appendix in the *FY 2017 President's Budget* for budgetary resources, obligations incurred, offsetting receipts, and net outlays (i.e., gross outlays less offsetting collections), as presented above.



For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Combined Statement of Budgetary Resources and not in the *President's Budget* is the budgetary resources that were not available. The Expired Accounts line in the above schedule includes expired authority, recoveries, and other amounts included in the Combined Statement of Budgetary Resources that are not included in the *President's Budget*.

The Other differences in the budgetary resources and obligations incurred are due to gift funds and trust funds reported on the HHS Combined Statement of Budgetary Resources but not in the *President's Budget*. Governmentwide Treasury Account Symbol revision window adjustments are not included in the HHS Combined Statement of Budgetary Resources but are included in the *President's Budget*. In addition, there are differences related to adjustments made to recoveries and spending authority.

**Note 18. Apportionment Categories of Obligations Incurred and Undelivered Orders** (in Millions)

	2016		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	\$ 102,101	\$ 8,418	\$ 110,519
Category B (Restricted and Distributed by Activity)	768,700	4,293	772,993
Exempt from Apportionment	724,276	15	724,291
<b>Total Obligations Incurred</b>	<b>\$ 1,595,077</b>	<b>\$ 12,726</b>	<b>\$ 1,607,803</b>

	2015		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	\$ 95,359	\$ 7,487	\$ 102,846
Category B (Restricted and Distributed by Activity)	700,591	3,832	704,423
Exempt from Apportionment	670,199	13	670,212
<b>Total Obligations Incurred</b>	<b>\$ 1,466,149</b>	<b>\$ 11,332</b>	<b>\$ 1,477,481</b>

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the Circular Number A-11, *Preparation, Submission and Execution of the Budget*, requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133, *Report on Budget Execution and Budgetary Resources*.

Undelivered Orders include obligations that have been issued but are not yet drawn down and goods and services ordered that have not been received. HHS reported \$140.2 billion of budgetary resources obligated for undelivered orders as of September 30, 2016 and \$105.8 billion as of September 30, 2015.

**Note 19. Funds from Dedicated Collections** (in Millions)

Medicare is the largest dedicated collections program managed by HHS and is presented in a separate column in the schedule below. The Medicare program includes the HI Trust Fund; the SMI Trust Fund which includes both Part B, medical insurance, and the Prescription Drug Benefit – Part D; and the Medicare Integrity Program. Portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds. See Note 1 for a description of each fund's purpose and how HHS accounts for and reports the funds.

	2016		
	Medicare	Other	Total
<b>Balance Sheet as of September 30</b>			
Fund Balance with Treasury	\$ 53,806	\$ 6,892	\$ 60,698
Investments	257,801	3,706	261,507
Other Assets	28,385	10,470	38,855
<b>Total Assets</b>	<b>\$ 339,992</b>	<b>\$ 21,068</b>	<b>\$ 361,060</b>
Entitlement Benefits Due and Payable	\$ 63,911	\$ 7,915	\$ 71,826
Accrued Liabilities (Note 12)	-	9,505	9,505
Other Liabilities	7,479	2,868	10,347
<b>Total Liabilities</b>	<b>\$ 71,390</b>	<b>\$ 20,288</b>	<b>\$ 91,678</b>
Unexpended Appropriations	36,012	(100)	35,912
Cumulative Results of Operations	232,590	880	233,470
<b>Total Liabilities and Net Position</b>	<b>\$ 339,992</b>	<b>\$ 21,068</b>	<b>\$ 361,060</b>
<b>Statement of Net Cost for the Period Ended September 30</b>			
Gross Program Costs	\$ 647,041	\$ 18,653	\$ 665,694
Less: Exchange Revenues	80,927	13,114	94,041
<b>Net Cost of Operations</b>	<b>\$ 566,114</b>	<b>\$ 5,539</b>	<b>\$ 571,653</b>
<b>Statement of Changes in Net Position for the Period Ended September 30</b>			
Net Position Beginning of Period	\$ 246,863	\$ 4,801	\$ 251,664
Nonexchange Revenue	264,044	346	264,390
Other Financing Sources	323,809	1,172	324,981
Net Cost of Operations	(566,114)	(5,539)	(571,653)
<b>Change in Net Position</b>	<b>\$ 21,739</b>	<b>\$ (4,021)</b>	<b>\$ 17,718</b>
<b>Net Position End of Period</b>	<b>\$ 268,602</b>	<b>\$ 780</b>	<b>\$ 269,382</b>

# NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

## Balance Sheet as of September 30

	2015		
	Medicare	Other	Total
Fund Balance with Treasury	\$ 44,785	\$ 6,598	\$ 51,383
Investments	263,993	3,606	267,599
Other Assets	7,327	10,661	17,988
<b>Total Assets</b>	<b>\$ 316,105</b>	<b>\$ 20,865</b>	<b>\$ 336,970</b>
Entitlement Benefits Due and Payable	\$ 66,221	\$ 4,195	\$ 70,416
Accrued Liabilities (Note 12)	-	10,419	10,419
Other Liabilities	3,021	1,450	4,471
<b>Total Liabilities</b>	<b>\$ 69,242</b>	<b>\$ 16,064</b>	<b>\$ 85,306</b>
Unexpended Appropriations	30,284	(100)	30,184
Cumulative Results of Operations	216,579	4,901	221,480
<b>Total Liabilities and Net Position</b>	<b>\$ 316,105</b>	<b>\$ 20,865</b>	<b>\$ 336,970</b>

## Statement of Net Cost for the Period Ended September 30

Gross Program Costs	\$ 622,836	\$ 26,545	\$ 649,381
Less: Exchange Revenues	75,701	23,813	99,514
<b>Net Cost of Operations</b>	<b>\$ 547,135</b>	<b>\$ 2,732</b>	<b>\$ 549,867</b>

## Statement of Changes in Net Position for the Period Ended September 30

Net Position Beginning of Period	\$ 237,110	\$ 6,656	\$ 243,766
Nonexchange Revenue	252,045	338	252,383
Other Financing Sources	304,843	539	305,382
Net Cost of Operations	(547,135)	(2,732)	(549,867)
Change in Net Position	\$ 9,753	\$ (1,855)	\$ 7,898
<b>Net Position End of Period</b>	<b>\$ 246,863</b>	<b>\$ 4,801</b>	<b>\$ 251,664</b>

## Note 20. Stewardship Land

IHS provides federal health services to American Indians and Alaska Natives to help raise their health status to the highest possible level. IHS provides health care to approximately 2.2 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 36 states. Health services are provided on tribal/reservation trust land that was transferred to IHS by the DOI for this purpose. Although the structures on this land are operational in nature, the land on which these structures reside is managed in a stewardship manner. All trust land, when no longer needed by IHS, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight. In FY 2016, the number of sites in Phoenix is reduced as a result of a reevaluation.

The table below presents stewardship land held by HHS:

Indian Trust Land by Locations and Number of Sites

	2016	2015
Albuquerque	4	4
Bemidji	2	2
Billings	7	7
Great Plains	9	9
Navajo	36	35
Oklahoma City	1	1
Phoenix	10	12
Portland	3	3
Tucson	5	5
Total	77	78

## Note 21. Incidental Custodial Collections

HHS reports custodial activities on the Consolidated Balance Sheets; however, HHS does not prepare a separate Statement of Custodial Activity, since custodial activities are incidental to its operations and the amounts collected are immaterial.

The majority of the custodial collections is funding ACF receives from the IRS for outlays to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. In addition, ACF transfers to the General Fund the federal share of state collections that were collected on behalf of children in the Temporary Assistance for Needy Families program and Foster Care Programs.

In FY 2016, the Department had custodial collections of \$2.9 billion of which \$2.6 billion was related to ACF. The Department made disbursements of \$2.9 billion of which \$2.6 billion was related to ACF.

In FY 2015, the Department had custodial collections of \$2.1 billion of which \$1.9 billion was related to ACF. The Department made disbursements of \$2.1 billion of which \$1.9 billion was related to ACF.

**Note 22. Reconciliation of Net Cost of Operations (Proprietary) to Budget** (in Millions)

	2016	2015
Resources Used to Finance Activities:		
Budgetary Resources Obligated		
New Obligations and Upward Adjustments	\$ 1,607,803	\$ 1,477,481
Spending Authority from Offsetting Collections and Recoveries	(63,331)	(60,006)
Obligations Net of Offsetting Collections and Recoveries	1,544,472	1,417,475
Distributed Offsetting Receipts	(428,128)	(380,187)
Net Obligations	\$ 1,116,344	\$ 1,037,288
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	367	1,332
Total Resources Used to Finance Activities	\$ 1,116,711	\$ 1,038,620
Resources Used to Finance Items Not Part of the Net Cost of Operations:		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	\$ 33,922	\$ (10,625)
Resources That Fund Expenses Recognized in Prior Periods	12	43
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	10,092	9,965
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	694	2,092
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	(2,511)	3,405
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	42,209	4,880
Total Resources Used to Finance the Net Cost of Operations	\$ 1,074,502	\$ 1,033,740
Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period		
Components Requiring or Generating Resources in Future Periods	\$ (1,024)	\$ (2,884)
Components Not Requiring or Generating Resources	1,294	(827)
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	270	(3,711)
Net Cost of Operations	\$ 1,074,772	\$ 1,030,029

**Note 23. Combined Schedule of Spending** (in Millions)

The Combined Schedule of Spending presents an overview of how departments or agencies are spending (i.e., obligating) money. The Combined Schedule of Spending presents total budgetary resources, total new obligations, and upward adjustments for the reporting entity. The data used to populate this schedule are the same underlying data used to populate the Combined Statement of Budgetary Resources. Simplified terms are used to improve the public's understanding of the budgetary accounting terminology used in the Combined Statement of Budgetary Resources.

OMB makes available a searchable website, [www.USAspending.gov](http://www.USAspending.gov)<sup>9</sup>, that provides information on federal awards of contracts and financial assistance awards (including grants) and is accessible to the public at no cost. When comparing [www.USAspending.gov](http://www.USAspending.gov) data to the Combined Schedule of Spending one must take into account that

<sup>9</sup> The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

## NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

the website has a fundamentally different purpose. There are differences due to object classes not reported to [www.USAspending.gov](http://www.USAspending.gov) that include but are not limited to personnel compensation, travel, utilities, and leases, intra-departmental and interagency spending, and various other categories of financial awards. In addition, the reporting entity between the financial statements and [www.USAspending.gov](http://www.USAspending.gov) differs for awards resulting from funding allocations between agencies, and/or HHS OpDivs. Also, recovery of prior year obligations are reported as deobligations on [www.USAspending.gov](http://www.USAspending.gov) but are not reported on the Combined Schedule of Spending. As a result, [www.USAspending.gov](http://www.USAspending.gov) data will differ from the Combined Schedule of Spending.

**What Money is Available to Spend?** This section presents resources that were available to spend, as reported in the Combined Statement of Budgetary Resources. Total Resources refers to Total Budgetary Resources as described in the Combined Statement of Budgetary Resources and represents amounts approved for spending by law. Amount Available but Not Agreed to be Spent represents amounts that HHS was allowed to spend but did not take action to spend by the end of the FY. Amount Not Available to be Spent represents amounts that HHS was not approved to spend during the current FY. Total Amounts Agreed to be Spent represents spending actions taken by HHS – including contracts, orders, grants, or other legally binding agreements of the federal government – to pay for goods or services. This line total agrees to the New Obligations and Upward Adjustments line in the Combined Statement of Budgetary Resources.

**Who did the Money Go To?** This section identifies the recipient of the money by federal and non-federal entities. Amounts in this section reflect amount agreed to be spent and agree to the New Obligations and Upward Adjustments line on the Statement of Budgetary Resources.

**How was the Money Spent/Issued?** This section presents services or items that were purchased, categorized by Treasury Symbol. Those Treasury Account Symbols that have a material impact on the Statement of Budgetary Resources are presented separately. Other Treasury Account Symbols, such as National Institute of Allergy and Infectious Diseases, Payments to States for Child Support Enforcement and Family Support Programs, Low Income Home Energy Assistance, National Heart, Lung, and Blood Institute, and Child Care Entitlement to States, are summarized under Other Agency Budgetary Accounts.

**Combined Schedule of Spending**

As of September 30, 2016 and 2015

(in Millions)

	FY 2016	FY 2015
<b>What Money is Available to Spend</b>		
Total Resources	\$ 1,668,313	\$ 1,543,105
Less Amount Available but Not Agreed to be Spent	17,280	23,828
Less Amount Not Available to be Spent	43,230	41,796
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 1,607,803</b>	<b>\$ 1,477,481</b>
 <b>Who did the Money Go To</b>		
Federal	\$ 9,105	\$ 8,142
Non-Federal	1,598,698	1,469,339
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 1,607,803</b>	<b>\$ 1,477,481</b>

**Combined Schedule of Spending**

As of September 30, 2016 and 2015

(in Millions)

How was the Money Spent/Issued?	FY 2016	FY 2015
<b>Medicaid</b>	<b>\$ 398,217</b>	<b>\$ 378,897</b>
Grants, Subsidies, and Contributions	393,919	375,142
Supplies and Materials	4,172	3,637
Other Contractual Services	108	101
Other	18	17
<b>Payments to Trust Funds</b>	<b>310,112</b>	<b>262,902</b>
Grants, Subsidies, and Contributions	215,830	195,385
Financial Transfers	94,282	67,445
Other	-	72
<b>Federal Supplementary Medical Insurance Trust Fund</b>	<b>306,562</b>	<b>281,640</b>
Financial Assistance Direct Payments	300,768	276,841
Financial Transfers	5,668	4,755
Other Contractual Services	126	44
<b>Federal Hospital Insurance Trust Fund</b>	<b>296,848</b>	<b>285,074</b>
Financial Assistance Direct Payments	291,252	277,004
Financial Transfers	5,594	8,068
Other	2	2
<b>Medicare Prescription Drug Account</b>	<b>92,804</b>	<b>80,583</b>
Financial Assistance Direct Payments	92,039	80,429
Financial Transfers	765	154
<b>Taxation on OASDI Benefits, HI</b>	<b>23,022</b>	<b>20,208</b>
Grants, Subsidies, and Contributions	23,022	20,208
<b>Temporary Assistance for Needy Families</b>	<b>16,722</b>	<b>16,717</b>
Grants, Subsidies, and Contributions	16,649	16,657
Other	73	60
<b>State Children's Health Insurance Fund</b>	<b>14,070</b>	<b>11,496</b>
Grants, Subsidies, and Contributions	14,002	11,486
Other	68	10
<b>Children and Families Services Programs</b>	<b>10,975</b>	<b>10,545</b>
Grants, Subsidies, and Contributions	10,509	10,121
Other Contractual Services	291	262
Personnel Compensation and Benefits	151	143
Other	24	19
<b>Payments for Foster Care and Permanency</b>	<b>7,858</b>	<b>7,387</b>
Grants, Subsidies, and Contributions	7,822	7,360
Other	36	27
<b>Transitional Reinsurance Program</b>	<b>7,846</b>	<b>8,249</b>
Financial Assistance Direct Payments	7,842	8,249
Other	4	-
<b>National Cancer Institute</b>	<b>5,392</b>	<b>5,386</b>
Grants, Subsidies, and Contributions	3,300	3,609
Other Contractual Services	1,457	1,178
Personnel Compensation and Benefits	511	504
Other	124	95
<b>Indian Health Services</b>	<b>5,250</b>	<b>5,702</b>
Grants, Subsidies, and Contributions	2,339	2,834
Personnel Compensation and Benefits	1,361	1,332
Other Contractual Services	847	803
Other	703	733
<b>Primary Health Care</b>	<b>5,041</b>	<b>4,700</b>
Grants, Subsidies, and Contributions	4,733	4,449
Other Contractual Services	232	200
Other	76	51
<b>Other Agency Budgetary Accounts</b>	<b>107,084</b>	<b>97,995</b>
Grants, Subsidies, and Contributions	57,034	51,862
Other Contractual Services	23,789	23,811
Other	14,117	12,664
Financial Assistance Direct Payments	12,144	9,658
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 1,607,803</b>	<b>\$ 1,477,481</b>

**Note 24. Statement of Social Insurance (Unaudited)**

The Statement of Social Insurance presents, for the 75-year projection period, the present values of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2016 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010-2011 Technical Review Panel.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on June 22, 2016 and do not reflect any actual or anticipated changes subsequent to that date. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Beginning with this year's projections, the Part A present values in the Statement of Social Insurance include the income and expenditures for the roughly 1 percent of beneficiaries who are 65 or over but are uninsured because they do not meet the normal insured status or related requirements to qualify for entitlement to Part A benefits. The reason that these beneficiaries were previously excluded is that their costs were separately funded either through general revenue appropriations or through premium payments, and accordingly the exclusion of such amounts did not materially affect the financial balance of Part A.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

The Statement of Social Insurance sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The Statement of Social Insurance also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future



income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the Statement of Social Insurance also sets forth the same calculation for the closed group of participants. The closed group consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the Statement of Social Insurance. Moreover, these differences could affect the long-term sustainability of this social insurance program.

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on June 22, 2016. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care costs, wages, and the consumer price index (CPI); fertility rates; mortality rates; immigration rates; and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2016 Statement of Social Insurance actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2016. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Similar detailed information for the prior years is publicly available on the CMS website at [www.cms.hhs.gov/CFORreport](http://www.cms.hhs.gov/CFORreport).<sup>10</sup>

<sup>10</sup> The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

**Table 1: Significant Assumptions and Summary Measures Used  
for the Statement of Social Insurance 2016**

	Fertility rate <sup>1</sup>	Net immigration <sup>2</sup>	Mortality rate <sup>3</sup>	Real-wage differential <sup>4</sup>	Annual percentage change in:						Real- interest rate <sup>9</sup>
					Wages <sup>5</sup>	CPI <sup>6</sup>	Real GDP <sup>7</sup>	Per beneficiary cost <sup>8</sup>			
								HI	SMI		
									B	D	
2016	1.90	1,579,000	773.0	2.08	2.94	0.86	2.8	0.9	2.1	0.9	1.2
2020	2.00	1,508,000	742.8	1.68	4.28	2.60	2.8	3.9	5.6	6.7	1.9
2030	2.00	1,332,000	679.1	1.30	3.90	2.60	2.1	3.9	4.5	4.7	2.7
2040	2.00	1,284,000	624.5	1.22	3.82	2.60	2.2	4.7	4.0	4.7	2.7
2050	2.00	1,259,000	576.8	1.25	3.85	2.60	2.2	3.8	3.7	4.6	2.7
2060	2.00	1,244,000	534.8	1.21	3.81	2.60	2.1	3.6	3.6	4.5	2.7
2070	2.00	1,235,000	497.6	1.15	3.75	2.60	2.1	3.8	3.6	4.4	2.7
2080	2.00	1,230,000	464.6	1.14	3.74	2.60	2.1	3.8	3.6	4.4	2.7
2090	2.00	1,228,000	435.1	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7

<sup>1</sup>Average number of children per woman.  
<sup>2</sup>Includes legal immigration, net of emigration, as well as other, non-legal, immigration.  
<sup>3</sup>The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.  
<sup>4</sup>Difference between percentage increases in wages and the CPI.  
<sup>5</sup>Average annual wage in covered employment.  
<sup>6</sup>Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.  
<sup>7</sup>The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.  
<sup>8</sup>These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.  
<sup>9</sup>Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the SOSI are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. Table 2 summarizes these ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports.

**Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance  
FY 2016-2012**

					Annual percentage change in:						
								Per beneficiary cost <sup>8</sup>			Real-interest rate <sup>9</sup>
								SMI			
	Fertility rate <sup>1</sup>	Net immigration <sup>2</sup>	Mortality rate <sup>3</sup>	Real-wage differential <sup>4</sup>	Wages <sup>5</sup>	CPI <sup>6</sup>	Real GDP <sup>7</sup>	HI	B	D	
FY 2016	2.0	1,228,000	435.1	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
FY 2015	2.0	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9
FY 2014	2.0	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	3.8	4.5	2.9
FY 2013	2.0	1,030,000	446.0	1.12	3.92	2.80	2.0	3.7	3.8	4.5	2.9
FY 2012	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9

<sup>1</sup>Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 12th year of the projection period.

<sup>2</sup>Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate level of net legal immigration is 795,000 persons per year, and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FYs 2012-2015 and is the value assumed in the year 2090 for FY 2016.

<sup>3</sup>The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FYs 2012-2015 and is the value assumed in the year 2090 for FY 2016.

<sup>4</sup>Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in Table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FYs 2012-2015 and is the value assumed in the year 2090 for FY 2016.

<sup>5</sup>Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FYs 2012-2015 and is the value assumed in the year 2090 for FY 2016.

<sup>6</sup>Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

<sup>7</sup>The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FYs 2012-2015 and is the value assumed in the year 2090 for FY 2016.

<sup>8</sup>These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FYs 2012-2015 and is the value assumed in the year 2090 for FY 2016.

<sup>9</sup>Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

## Note 25. Alternative Statement of Social Insurance Projections (Unaudited)

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results.

The Trustees assume that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide private nonfarm business multifactor productivity and the specified physician updates put in place by MACRA—will occur as current law requires. The Board of Trustees believes that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. For those providers affected by the productivity adjustments and the specified updates to physician payments, sustaining the price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The gap will continue to widen throughout the projection, and the Trustees anticipate that physician payment rates under current law will

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be lower than they would have been under the sustainable growth rate (SGR) formula by 2048. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term under current law. Overriding the productivity adjustments and specified physician updates, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent and, starting in 2025, physician payments transition from a payment update of 0.0 percent to an increase of 2.2 percent. In addition, the illustrative alternative assumes that the 5 percent bonuses paid to physicians in alternative payment models (APMs) would continue and that the Independent Payment Advisory Board (IPAB) requirements would not be implemented.<sup>11</sup> This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

The table below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

### Medicare Present Values

(in Billions)

	Current law (Unaudited)	Alternative scenario <sup>1,2</sup> (Unaudited)
Income		
Part A	\$20,701	\$20,874
Part B	27,484	34,465
Part D	12,213	12,411
Expenditures		
Part A	24,523	30,598
Part B	27,484	34,465
Part D	12,213	12,411
Income less expenditures		
Part A	(3,822)	(9,723)
Part B	-	-
Part D	-	-
<sup>1</sup> These amounts are not presented in the 2016 Trustees Report. <sup>2</sup> At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections that differs from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.		

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.1 percent reduction in annual cost growth each

<sup>11</sup>The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the Affordable Care Act. The assumption regarding physician payments is being used because the SGR was replaced in 2015.

year for these providers. If the productivity adjustments were gradually phased out, the physician updates transitioned to the Medicare Economic Index update of 2.2 percent, the 5 percent bonuses paid to physicians in APMs did not expire, and the IPAB requirements were not implemented, as illustrated under the alternative scenario, the estimated present values of Part A and Part B expenditures would each be higher than the current-law projections by roughly 25 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is also 25 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected by the productivity adjustments or the physician updates. The very minor effect is the result of the removal of the IPAB impact and a slight change in the discount rates that are used to calculate the present values.

The extent to which actual future Part A and Part B costs exceed the projected amounts due to changes to the productivity adjustments and physician updates depends on what specific changes might be legislated and whether Congress would pass further provisions to help offset such costs. As noted, these examples reflect only hypothetical changes to provider payment rates.

#### **Note 26. Statement of Changes in Social Insurance Amounts (Unaudited)**

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future non-interest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The Statement of Changes in Social Insurance Amounts shows the reconciliation from the period beginning on January 1, 2015 to the period beginning on January 1, 2016, and the reconciliation from the period beginning on January 1, 2014 to the period beginning on January 1, 2015. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated future expenditures has the same effect on estimated total future income, and vice versa. Therefore, any change has no impact on the estimated future net cash flow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

The five changes considered in the Statement of Changes in Social Insurance Amounts are, in order:

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and health care assumptions, and
- changes in law.

All estimates in the Statement of Changes in Social Insurance Amounts represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cash flows represents a positive change

(improving financing), while a decrease in the present value of net cash flows represents a negative change (worsening financing).

### **Assumptions Used for the Statement of Changes in Social Insurance Amounts**

The present values included in the Statement of Changes in Social Insurance Amounts are for the current and prior year and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of Note 24 summarizes these assumptions for the current year.

#### **Period beginning on January 1, 2015 and ending January 1, 2016**

Present values as of January 1, 2015 are calculated using interest rates from the intermediate assumptions of the 2015 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2016. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2015 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2016 Trustees Report.

#### **Period beginning on January 1, 2014 and ending January 1, 2015**

Present values as of January 1, 2014 are calculated using interest rates from the intermediate assumptions of the 2014 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2015. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2014 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2015 Trustees Report.

### **Change in the Valuation Period**

#### **From the period beginning on January 1, 2015 to the period beginning on January 1, 2016**

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2015-89) to the current valuation period (2016-90) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2015, replaces it with a much larger negative net cash flow for 2090, and measures the present values as of January 1, 2016, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (became more negative) when the 75-year valuation period changed from 2015-89 to 2016-90. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2015 are realized. The change in valuation period slightly increased the starting level of assets in the combined Medicare Trust Funds.

#### **From the period beginning on January 1, 2014 to the period beginning on January 1, 2015**

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2014-88) to the current valuation period (2015-89) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cash flow for 2014 and replaces it with a much larger negative net cash flow for 2089. The present value of estimated future net cash flow (including or excluding the combined Medicare

Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2014-88 to 2015-89. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2014 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

## Change in Projection Base

### From the period beginning on January 1, 2015 to the period beginning on January 1, 2016

Actual income and expenditures in 2015 were different than what was anticipated when the 2015 Trustees Report projections were prepared. Part A income and expenditures were higher than anticipated, based on actual experience. Part B total income and expenditures were lower than estimated based on actual experience. For Part D, actual income and expenditures were both higher than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2015 and January 1, 2016 is incorporated in the current valuation and is slightly less than projected in the prior valuation.

### From the period beginning on January 1, 2014 to the period beginning on January 1, 2015

Actual income and expenditures in 2014 were different than what was anticipated when the 2014 Trustees Report projections were prepared. Part A income was very slightly lower and expenditures were very slightly higher than anticipated, based on actual experience. Part B total income and expenditures were also higher than estimated based on actual experience. For Part D, actual income and expenditures were both higher than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2014 and January 1, 2015 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

## Changes in the Demographic Assumptions

### From the period beginning on January 1, 2015 to the period beginning on January 1, 2016

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2016), with the exception of a small change in marriage rates, are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2013 and 2014 indicated lower birth rates than were expected in the prior valuation. The data also show an increase in birth rates starting in 2014, one year later than assumed in the prior valuation.
- Incorporating mortality data obtained from the National Center for Health Statistics at ages under 65 for 2012 and 2013 and from Medicare experience at ages 65 and older for 2013 resulted in slightly higher death rates than were projected in the prior valuation.
- Assumed ultimate marriage rates were decreased somewhat to reflect a continuation of recent trends.
- More recent legal and other-than-legal immigration data and historical population data were included.

There were two changes in demographic methodology:

- The transition from recent mortality rates to the ultimate rates starts sooner, immediately after the year of final data. The approach used for the prior valuation extended the trend of the last 10 years through the valuation year for the report and only thereafter started the transition to assumed ultimate rates of decline.
- Historical non-immigrant population counts were revised to match recent totals provided by the Department of Homeland Security. In addition, emigration rates for the never-authorized and visa-overstay populations were recalibrated to reflect a longer historical period and to be less influenced by the high emigration rates experienced during the recent recession. Finally, the method for projecting emigration of the never-authorized population was altered to reflect lower rates of emigration for those who have resided here longer.

These changes slightly lowered overall Medicare enrollment for the current valuation period and resulted in an increase in the estimated future net cash flow. The present value of estimated expenditures is lower for all parts of Medicare; and the present value of estimated income is also lower for Parts B and D but very slightly higher for Part A.

#### **From the period beginning on January 1, 2014 to the period beginning on January 1, 2015**

The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2015), with the exception of changes made due to the execution on immigration, are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2012 and preliminary data for 2013 indicated lower birth rates than were expected in the prior valuation. In this year's report, the total fertility rate reaches the ultimate in 2027, which is eleven years earlier than in last year's projections.
- Incorporating mortality data obtained from Medicare experience at ages 65 and older for 2012 resulted in slightly higher death rates for 2012 and a slightly slower rate of decline in mortality over the next 25 years than were projected last year. Incorporating mortality data obtained from the National Centers for Health Statistics at ages under 65 for 2011 resulted in slightly lower death rates for 2011 and a slightly faster rate of decline in mortality over the next 25 years than were projected last year.
- Historical legal immigration was revised to include single age data (rather than 5-year age groups); including more recent marriage, legal immigration, and other-than-legal immigration data; historical data since 2001 was revised to be more consistent with the most recent estimates from the Census Bureau.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cash flow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.

### **Changes in Economic and Health Care Assumptions**

#### **For the period beginning on January 1, 2015 to the period beginning on January 1, 2016**

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at SSA.



For the current valuation (beginning on January 1, 2016), there were three changes to the ultimate economic assumptions.

- The ultimate rate of price inflation (CPI-W) was lowered by 0.1 percentage point, to 2.6 percent from 2.7 percent for the previous valuation.
- The ultimate average real wage differential is assumed to be 1.20 percent in the current valuation period, compared to 1.17 percent in the previous valuation period.
- The ultimate real interest rate was lowered by 0.2 percentage point, to 2.7 percent from 2.9 percent for the previous valuation period.

While very low inflation in recent years is reflective of U.S. and international supply and demand factors that have been affected by the global recession, the average rate of change in the CPI-W over the last two complete business cycles (from 1989 to 2007) is 2.63 percent.

The higher real wage differential assumption is based on new projections by the CMS of slower growth in employer-sponsored group health insurance premiums. Because these premiums are not subject to the payroll tax, slower growth in these premiums means that a greater share of employee compensation will be in the form of wages that are subject to the payroll tax.

Real interest rates have been low since 2000, and particularly low since the start of the recent recession. An ongoing and much-debated question among experts is how much of this change is cyclic or a temporary response to extraordinary events, versus a fundamental permanent change. The Trustees believe that lowering the long-term ultimate real interest rate somewhat is appropriate at this time. The long-range present values are very sensitive to the ultimate interest rate assumption because they are used as the discount factor. The reduction in the ultimate interest rate assumption from 2.9 percent to 2.7 percent increases each of the present values by roughly 15-16 percent.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed.

- A reduction in the ultimate level of actual and potential gross domestic product (GDP) of about 1.0 percent is assumed. Thus, by the end of the short-range period (2025) and for all years thereafter, projected GDP in 2009 dollars is about 1.8 percent below the level in last year's report.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Utilization rate assumptions for inpatient hospital services were increased.
- The number of beneficiaries enrolled in Medicare Advantage plans and their relative costs are slightly different from last year's assumptions.
- Lower productivity increases through 2021, resulting in higher provider payment updates.
- Greater reductions in expenditures attributable to the Independent Payment Advisory Board.
- Inclusion of the income and expenditures for aged non-insured beneficiaries in the Part A long-range analysis.
- Higher projected drug cost trend, particularly for certain high-cost specialty drugs.

The net impact of these changes resulted in a decrease in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and

income, with an overall decrease in the estimated future net cash flow. For Part B and Part D, these changes increased the present value of estimated future expenditures (and also income).

**For the period beginning on January 1, 2014 to the period beginning on January 1, 2015**

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2015), there was one change to the ultimate economic assumptions.

- The ultimate real-wage differential is assumed to be 1.17 percent in the current valuation period, compared to 1.13 percent in the previous valuation period.

The higher real wage differential assumption is more consistent with recent experience and expectations of slower growth in employer-sponsored group health insurance premiums from the Office of the Actuary at the CMS. Because these premiums are not subject to the payroll tax, slower growth in these premiums means that a greater share of employee compensation will be in the form of wages that are subject to the payroll tax.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed.

- The ratio of average taxable earnings to the average wage averages about 0.6 percentage point higher during the long-range period, compared to the previous valuation period.
- The projected suspense file contains fewer wage items, which is consistent with having fewer workers (many of whom are undocumented immigrants) with wages on the suspense file and more of these workers with earnings in the underground economy, compared to the previous valuation.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Lower long-range growth rate assumptions.
- Utilization rate assumptions for inpatient hospital services were decreased.
- Lower assumed hospice spending.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Introduction of high-cost specialty drugs used to treat hepatitis C.

The net impact of these changes resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and income, with an overall increase in the estimated future net cash flow. For Part B and Part D, these changes decreased the present value of estimated future expenditures (and also income).

## Changes in Law

### For the period beginning on January 1, 2015 to the period beginning on January 1, 2016

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions did have a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

- The *Trade Preference Extension Act of 2015* requires Medicare coverage for renal dialysis services provided by outpatient renal dialysis facilities to individuals with acute kidney injury, effective January 1, 2017.
- The *Bipartisan Budget Act of 2015* (BBA) included provisions that affect the HI and SMI programs.
  - The BBA required that the 2016 actuarial rate for enrollees aged 65 and older be determined as if the hold-harmless provision did not apply, thereby lowering the standard Part B premium rate from what it otherwise would have been. The premium revenue that was lost by using the resulting lower premium (excluding the forgone income-related premium revenue) was to be replaced by a transfer of general revenue from the Treasury, which will be repaid over time to the general fund. Starting in 2016, in order to repay the balance due (which is to include the transfer amount and the forgone income-related premium revenue), the monthly Part B premium otherwise determined is to be increased by \$3.00. These repayment amounts are to be added to the Part B premium otherwise determined each year and paid back to the general fund of the Treasury. This \$3.00 increase will not be matched by government contributions. These repayment amounts are to continue until the total amount collected is equal to the beginning balance due. (In the final year of the repayment, the additional amounts may be modified to avoid an overpayment). The repayment amounts (excluding those for high-income enrollees) are subject to the hold-harmless provision. The BBA also stipulated that if the Social Security cost-of-living adjustment (COLA) was 0 percent in 2017, then an additional transfer (and \$3 repayment amount) would have again applied. However, the 2017 COLA of 0.3 percent was released on October 18, 2016.
  - Most outpatient hospital services provided on or after January 1, 2017 by new off-campus hospital provider-based outpatient departments (that is, those established on or after the BBA date of enactment of November 2, 2015 and located more than 250 yards from the campus) are excluded from the outpatient hospital prospective payment system, and are instead to be reimbursed under the applicable Part B payment system.
  - The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by one year, through FY 2025. In addition, Medicare benefit payments for services provided under periods of sequestration incur a payment reduction limited to 2 percent, so that the former differential payment reduction limits imposed for fiscal years 2023 and 2024 are replaced with 2 percent limits. Finally, the 2 percent limit is raised to 4.0 percent for the first six months of FY 2025 and reduced to 0.0 percent for the last six months of FY 2025.
- The *Consolidated Appropriations Act of 2016* included provisions that affect the HI and SMI programs.
  - The payment calculation associated with inpatient hospital operating costs for Puerto Rico hospital discharges on or after January 1, 2016 is to be based on 0 percent of the applicable Puerto Rico percentage and 100 percent of the applicable Federal percentage. (In addition, CMS announced that both the FY 2016 Inpatient Prospective Payment System Pricer and the Long-Term Care Hospital Pricer, which are used to determine all inpatient hospital payment rates and certain long-term care hospital payment rates, respectively, for providers nationwide, are to incorporate the Puerto Rico inpatient hospital payment modification. These conforming changes are applicable to inpatient hospital discharges and long-term care hospital discharges on or after January 1, 2016.)

- Puerto Rico hospitals are eligible to receive incentive payments under the Medicare Electronic Health Records Incentive Program, effective January 1, 2016.
- Effective January 1, 2017, separate Medicare payment is authorized to home health agencies when they use cost-effective disposable alternatives to negative pressure wound therapy equipment.
- To incentivize the transition from traditional x-ray imaging to digital radiography, Part B payment for the technical component of film x-rays, under the hospital outpatient prospective payment system and under the physician fee schedule, is reduced by 20 percent beginning in 2017. In addition, payment for the technical component of x-rays taken using computed radiography technology is reduced by 7 percent during 2018 through 2022 and by 10 percent beginning in 2023. Also, the discount in payment for the professional component of multiple imaging services furnished on or after January 1, 2017 is reduced from 25 percent to 5 percent, and the reduction is taken in a non-budget neutral manner.
- A one-year moratorium for calendar year 2017 is placed on the annual fee to be paid by health insurance providers. This fee, which was established by the *Affordable Care Act*, is imposed on certain large health insurance providers, including those furnishing coverage under Medicare Advantage (Part C) and Medicare Part D. (Since Medicare Advantage is paid for by the HI trust fund and the Part B account of the SMI trust fund, this provision affects all parts of Medicare.)

Overall these provisions resulted in a slight increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in a slight decrease to the present value of estimated future expenditures, with an overall increase in the estimated future net cash flow. For Part B, these changes decreased the present value of estimated future expenditures (and also income). For Part D, the above-mentioned changes also resulted in a lower present value of estimated future expenditures (and also income) but only very slightly.

#### **For the period beginning on January 1, 2014 to the period beginning on January 1, 2015**

Although Medicare legislation was enacted since the prior valuation date, some of the provisions have a negligible impact on the present value of the 75-year estimated future income, expenditures, and net cash flow. The *Veteran's Access, Choice, and Accountability Act of 2014* established a temporary program that allows eligible veterans to receive hospital care and medical services from eligible providers outside of the Department of Veterans Affairs (VA) system, rather than waiting for a VA appointment or traveling to a VA facility. The *Improving Medicare Post-Acute Care Transformation Act of 2014* standardized the collection of data for post-acute providers and aligned the inflation of the hospice aggregate cap with that of hospice reimbursement. The *Tax Increase Prevention Act of 2014* accelerated the start date for the payment adjustment of misvalued codes under the physician fee schedule from 2017 to 2016, and delayed inclusion of oral-only end-stage renal disease (ESRD)-related drugs into the ESRD bundled payment system from 2024 to 2025. MACRA included many provisions affecting Medicare spending, including the repeal of the SGR formula for determining payments under the physician fee schedule, the continuation of extensions for several provisions from prior legislation, a reduction in payment updates for most post-acute providers in 2018, the replacement of a 3.2 percent reduction to inpatient hospitals in 2018 with a 0.5 percent reduction in 2018 through 2023, and a revision to the income thresholds for determining the income-related monthly adjustment amounts under Part B and Part D.

Overall these provisions resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in a decrease to the present value of estimated future expenditures, with an overall increase in the estimated future net cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income). For Part D, the above-mentioned changes decreased the present value of estimated future expenditures (and also income) only very slightly.

**Potential Impact on the Social Insurance Statements of the June 23, 2016 Supreme Court Judgment on the 2014 DACA and DAPA Executive Actions**

In November 2014, Presidential executive actions expanded the Deferred Action for Childhood Arrivals program (DACA) and established the Deferred Action for Parents of Americans program (DAPA). On June 23, 2016, the Supreme Court was divided (tied 4-4) on the ruling of the legality of the expanded DACA and DAPA programs, so the lower court's ruling, temporarily blocking these programs from being implemented, was upheld. As a result, the expanded DACA and DAPA programs will be either delayed or never implemented. The SSA Office of the Chief Actuary has concluded that the Supreme Court's judgment has an effect on the actuarial methods and assumptions used in developing the estimates presented in the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. Whether the expanded DACA and DAPA programs are delayed or never implemented, we expect the judgment will not have a material impact on the present value of future noninterest income less future costs for current and future participants (open group measure) presented in the Statements of Social Insurance and Statement of Changes in Social Insurance Amounts.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

## Investment in Human Capital (in Millions)

For the Year Ended September 30, 2016

Responsibility Segment Program	2016	2015	2014	2013	2012
National Institutes of Health					
Research Training and Career Development	\$ 1,745	\$ 1,631	\$ 1,541	\$ 1,621	\$ 1,858
Health Resources and Services Administration					
Scholarships Loan Repayments and Loans	935	828	660	766	705
Other HRSA Training Investments	90	-	-	-	-
Other Investments in Human Capital					
Other	17	14	8	6	6
Totals	\$ 2,787	\$ 2,473	\$ 2,209	\$ 2,393	\$ 2,569

Investments in Human Capital are expenses incurred by federal education and training programs for the public, intended to maintain or increase national productive capacity. The following OpDivs conduct education and training programs under this category:

### National Institutes of Health

The NIH Research Training and Career Development Programs address the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for research training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the nation's health. NIH's major research training and career development programs include institutional research training grants for graduate students and post-doctoral scholars, individual pre- and post-doctoral fellowships, individual and institutional research career development awards for advanced post-doctorates and early-stage faculty, loan repayment programs, and research education awards that promote research experiences, curriculum development, and other related activities. These programs are administered by NIH institutes and centers with awarding authority, and are key to NIH's ability to maintain the momentum of recent scientific progress and international leadership in medical research.

### Health Resources and Services Administration

HRSA's Bureau of Health Workforce (BHW) improves the health of the nation's underserved communities and vulnerable populations by developing, implementing, evaluating, and refining programs that strengthen the nation's health care workforce. BHW programs support a diverse, culturally competent workforce by addressing components including education, training, and financial support for students, faculty, practitioners, and supporting institutions. These efforts support development of a skilled health workforce serving in areas of the nation with the greatest need. In FY 2016 and FY 2015, BHW awarded more than \$1.0 billion to organizations and individuals. These funds were distributed among BHW's scholarships, loans, loan repayment programs, health professions training programs, and programs supporting graduate medical education.

In FY 2016 HRSA gave Maternal and Child Health (MCH) Workforce Development grants to support lifelong learning, intended to encourage high school and college students to enter MCH professions and graduate training programs, to educate the next generation of MCH leaders, and to encourage continuing education for practicing MCH professionals. Additionally, HRSA gave human immunodeficiency virus (HIV) acquired immunodeficiency

syndrome grants to provide support to the Education and Training Center Program that conducts targeted, multidisciplinary education and training programs for health care providers treating people living with HIV.

### Other Investments in Human Capital

Administered by ACL, Projects of National Significance grants and contracts are awarded to public and private non-profit institutions to enhance the independence, productivity, integration, and inclusion into the community of people with developmental disabilities. These monies also support the development of national and state policy to serve this community. ACL also presides over the Administration for Intellectual and Developmental Disabilities program. As of September 30, 2016, 24 grants (totaling \$7.5 million) and 8 contracts (totaling \$2.3 million) have been awarded for FY 2016. This program works to ensure that individuals with developmental disabilities and their families are able to fully participate in and contribute to all aspects of community life.

In addition, AHRQ provides an array of pre-doctoral and postdoctoral educational and career development grants and opportunities in health services research training. Research training and career development activities are administered by the Division of Research Education in the Office of Extramural Research, Education, and Priority Populations.

### Investment in Research and Development (in Millions)

For the Year Ended September 30, 2016

Responsibility Segments	Basic	Applied	Develop- mental	2016 Total	2015	2014	2013	2012	Grand Total
AHRQ	\$ -	\$ 213	\$ -	\$ 213	\$ 167	\$ 250	\$ 372	\$ 401	\$ 1,403
CDC	88	388	26	502	490	394	457	408	2,251
FDA	163	-	7	170	129	103	94	80	576
NIH	16,955	11,303	-	28,258	28,093	27,719	29,328	30,681	144,286
Other	2	30	-	32	26	3	1	2	64
<b>Totals</b>	<b>\$ 17,208</b>	<b>\$ 11,934</b>	<b>\$ 33</b>	<b>\$ 29,175</b>	<b>\$ 28,905</b>	<b>\$ 28,469</b>	<b>\$ 30,252</b>	<b>\$ 31,572</b>	<b>\$ 148,580</b>

The research and development programs in HHS include the following:

### Agency for Healthcare Research and Quality

AHRQ is the leading federal agency charged with improving the safety and quality of America's health care system. AHRQ develops knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions. AHRQ supports health services research that will improve the quality of health care and promote evidence based decision making.

### Centers for Disease Control and Prevention

Diseases, Occupational Safety and Health, Health Promotion, and Environmental Health and Injury Prevention were the primary areas where CDC's research and development was invested. CDC works with partners around the country and world to protect Americans from infectious diseases; prevent the leading causes of disease, disability, and death; ensure global disease protection; keep Americans safe from environmental and work-related hazards; protect Americans from natural and bioterrorism threats; monitor health; and ensure laboratory excellence. CDC programs provide partners and Americans with the essential health information and tools they

need to protect and advance their health. In 2016, CDC developed and published the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for prescribing opioid pain medication to patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (i.e., pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care. For more information, visit [www.cdc.gov/media/releases/2015/p1228-eoy.html](http://www.cdc.gov/media/releases/2015/p1228-eoy.html)

## Food and Drug Administration

FDA has two programs that meet the requirements of research and development investments: Orphan Products Designation (OPD) Program and FDA Research Grants Program. While the FDA's center components conduct scientific studies, FDA does not consider this type of research as "research and development" because it is used to support FDA's regulatory policy and decision making processes.

The OPD Program was established by the *Orphan Drug Act* with the purpose of identifying orphan products and facilitating their development. The *Orphan Drug Act* also created the Orphan Product Clinical Trials Grants Program to stimulate the development of promising products for rare diseases and conditions. Orphan product grants are a proven method of fostering and encouraging the development of new, safe, and effective medical products for rare diseases and conditions. Since Orphan Products Clinical Trials Grants Program's inception in 1983, FDA has received over 2,500 applications (generally, about 100 applications each year), reviewed over 2,200, and funded over 590 studies. The program has been used to bring more than 55 products to marketing approval. Approximately 10 percent of the studies that received developmental support from the OPD Grants Program have been utilized to facilitate the marketing approval of those drugs, biologics, and medical devices. In FY 2016, FDA funded 21 new grant awards – out of 68 grant applications – and provided funding or continued support for approximately 65 other ongoing clinical study projects. For more information about the Orphan Products Clinical Trials Grants Program, including grants funded to date, visit [www.fda.gov/forIndustry/DevelopingProductsforRareDiseasesConditions/WhomtoContactaboutOrphanProductDevelopment/default.htm](http://www.fda.gov/forIndustry/DevelopingProductsforRareDiseasesConditions/WhomtoContactaboutOrphanProductDevelopment/default.htm)

The FDA Research Grants Program is a grants program whose purpose is to assist public and non-public institutions and for-profit organizations to establish, expand, and improve research, demonstration, education, and information dissemination activities concerned with a wide variety of FDA areas.

## National Institutes of Health

The NIH Research Program includes all aspects of the medical research continuum, including basic and disease-oriented research, observational, and population-based research, behavioral research and clinical research, including research to understand both health and disease states, to move laboratory findings into medical applications, to assess new treatments or compare different treatment approaches, and health services research. NIH regards the expeditious transfer of the results of its medical research for further development and commercialization of products an immediate benefit to improved health and an important mandate.

NIH issues yearly research highlights in December each year. The highlights cover Clinical Advances/Breakthroughs, Promising Medical Advances, and Insights from the Lab. In 2015, these honors included three NIH-supported Nobel Prize winners and two NIH-funded recipients of top awards from the Lasker Foundation. For more information on the yearly highlights, visit [www.nih.gov/research-training/nih-research-highlights](http://www.nih.gov/research-training/nih-research-highlights).



## Other Investments in Research and Development

ACF oversees research and development programs that contribute to a better understanding of how to improve the economic and social well-being of families and children so that they may lead healthier and more productive lives. HRSA conducts health services research that will improve the quality of health care, increase capacity, and promote evidence-based decision making. Applied research includes MCH research programs to solve needs for current and emerging maternal and child health programs and help MCH professionals with planning and policymaking. Healthcare Systems conduct research for public outreach campaigns to promote organ, eye, and tissue donation. Rural Health programs produce policy-relevant research on health care and population health in rural areas. HRSA's basic research supports the causes, diagnosis, prevention, and cure of Hansen's disease.

## REQUIRED SUPPLEMENTARY INFORMATION

### Combining Statement of Budgetary Resources (in Millions)

For the Year Ended September 30, 2016

	CMS						Non-Budgetary Credit Reform Financing Account
Budgetary Resources:	Medicare HI	Medicare SMI	Payments to Trust Fund	Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	
Unobligated Balance, Brought Forward, Oct 1	\$ -	\$ -	\$ 27,047	\$ 334	\$ 38,241	\$ 65,622	\$ 2
Recoveries of Unpaid Prior Year Obligations	2	1	484	30,726	5,120	36,333	-
Other Changes in Unobligated Balance	2	4	(3,659)	7	548	(3,098)	-
Unobligated Balance from Prior Year Budget Authority, Net	4	5	23,872	31,067	43,909	98,857	2
Appropriations (Discretionary and Mandatory)	296,844	314,009	333,197	362,295	233,888	1,540,233	-
Borrowing Authority (Discretionary and Mandatory)	-	3,720	-	-	-	3,720	19
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	(11,172)	-	872	35,144	24,844	638
<b>Total Budgetary Resources</b>	<b>\$ 296,848</b>	<b>\$ 306,562</b>	<b>\$ 357,069</b>	<b>\$ 394,234</b>	<b>\$ 312,941</b>	<b>\$ 1,667,654</b>	<b>\$ 659</b>
<b>Status of Budgetary Resources:</b>							
New Obligations and Upward Adjustments	\$ 296,848	\$ 306,562	\$ 333,236	\$ 393,821	\$ 277,304	\$ 1,607,771	\$ 32
Unobligated Balance, End of Year:							
Apportioned, Unexpired Accounts	-	-	-	140	24,842	24,982	8
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	(7,710)	(7,710)	-
Unapportioned, Unexpired Accounts	-	-	-	273	4,809	5,082	619
Unexpired Unobligated Balance, End of Year	-	-	-	413	21,941	22,354	627
Expired Unobligated Balance, End of Year	-	-	23,833	-	13,696	37,529	-
Unobligated Balance, End of Year	-	-	23,833	413	35,637	59,883	627
<b>Total Status of Budgetary Resources</b>	<b>\$ 296,848</b>	<b>\$ 306,562</b>	<b>\$ 357,069</b>	<b>\$ 394,234</b>	<b>\$ 312,941</b>	<b>\$ 1,667,654</b>	<b>\$ 659</b>
<b>Change in Obligated Balance:</b>							
<b>Unpaid Obligation:</b>							
Unpaid Obligations, Brought Forward, Oct 1	\$ 32,616	\$ 23,481	\$ 14,161	\$ 41,572	\$ 124,518	\$ 236,348	\$ 375
New Obligations and Upward Adjustments	296,848	306,562	333,236	393,821	277,304	1,607,771	32
Outlays (Gross)	(297,203)	(304,020)	(319,843)	(364,613)	(264,509)	(1,550,188)	(370)
Recoveries of Prior Year Unpaid Obligations	(2)	(1)	(484)	(30,726)	(5,120)	(36,333)	-
<b>Unpaid Obligations, End of Year</b>	<b>\$ 32,259</b>	<b>\$ 26,022</b>	<b>\$ 27,070</b>	<b>\$ 40,054</b>	<b>\$ 132,193</b>	<b>\$ 257,598</b>	<b>\$ 37</b>
<b>Uncollected Payments:</b>							
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	\$ -	\$ (11,172)	\$ -	\$ -	\$ (10,952)	\$ (22,124)	\$ (160)
Change in Uncollected Customer Payments from Federal Sources	-	11,172	-	(105)	(15,409)	(4,342)	145
<b>Uncollected Payments from Federal Sources, End of Year</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ (105)</b>	<b>\$ (26,361)</b>	<b>\$ (26,466)</b>	<b>\$ (15)</b>
<b>Memorandum (non-add) Entries:</b>							
Obligated Balance, Start of Year	\$ 32,616	\$ 12,309	\$ 14,161	\$ 41,572	\$ 113,566	\$ 214,224	\$ 215
Obligated Balance, End of Year	\$ 32,259	\$ 26,022	\$ 27,070	\$ 39,949	\$ 105,832	\$ 231,132	\$ 22

[1] Other Agency Budgetary Accounts includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of \$4.4 billion and net outlays of \$4.4 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

REQUIRED SUPPLEMENTARY INFORMATION

Combining Statement of Budgetary Resources (continued) (in Millions)

For the Year Ended September 30, 2016

CMS							
	Medicare HI	Medicare SMI	Payments to Trust Funds	Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
<b>Budget Authority and Outlays, Net:</b>							
Budget Authority, Gross (Discretionary and Mandatory)	\$ 296,844	\$ 306,557	\$ 333,197	\$ 363,167	\$ 269,032	\$ 1,568,797	\$ 657
Actual Offsetting Collections (Discretionary and Mandatory)	(2)	(4)	(111)	(774)	(21,128)	(22,019)	(782)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	-	11,172	-	(105)	(15,409)	(4,342)	145
Recoveries of Prior Year Paid Obligations (Discretionary and Mandatory)	2	4	111	7	389	513	-
<b>Budget Authority, Net (Discretionary and Mandatory)</b>	<b>\$ 296,844</b>	<b>\$ 317,729</b>	<b>\$ 333,197</b>	<b>\$ 362,295</b>	<b>\$ 232,884</b>	<b>\$ 1,542,949</b>	<b>\$ 20</b>
Outlays, Gross (Discretionary and Mandatory)	\$ 297,203	\$ 304,020	\$ 319,843	\$ 364,613	\$ 264,509	\$ 1,550,188	\$ 370
Actual Offsetting Collections (Discretionary and Mandatory)	(2)	(4)	(111)	(774)	(21,128)	(22,019)	(782)
Outlays, Net (Discretionary and Mandatory)	297,201	304,016	319,732	363,839	243,381	1,528,169	(412)
Distributed Offsetting Receipts	(35,450)	(391,627)	-	-	(1,051)	(428,128)	-
<b>Agency Outlays, Net (Discretionary and Mandatory)</b>	<b>\$ 261,751</b>	<b>\$ (87,611)</b>	<b>\$ 319,732</b>	<b>\$ 363,839</b>	<b>\$ 242,330</b>	<b>\$ 1,100,041</b>	<b>\$ (412)</b>

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	\$ 55,658	\$ 55,658	\$ 50,237
ACL	2,056	2,056	1,973
AHRQ	377	377	269
CDC	15,872	15,872	11,937
CMS	162,891	162,891	124,643
FDA	5,944	5,944	2,539
HRSA	11,577	11,577	10,263
IHS	7,649	7,649	4,704
NIH	38,472	38,472	29,229
OS	6,290	6,290	2,619
PSC	2,186	2,186	474
SAMHSA	3,969	3,969	3,443
<b>Totals</b>	<b>\$ 312,941</b>	<b>\$ 312,941</b>	<b>\$ 242,330</b>

1) Other Agency Budgetary Accounts includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of \$4.4 billion and net outlays of \$4.4 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

## REQUIRED SUPPLEMENTARY INFORMATION

**Deferred Maintenance and Repairs**

For the Years Ended September 30, 2016 and 2015

The FASAB issued SFFAS No. 42, *Deferred Maintenance and Repairs*: Amending Statement of Federal Financial Accounting Standards 6, 14, 29, and 32 effective for periods after September 30, 2014. This standard clarifies that repair activities should be included to better reflect asset management practices, and improve reporting on deferred maintenance and repairs. Deferred maintenance and repairs are maintenance and repairs activities not performed when they should have been or were scheduled to be, and then put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed capital assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components, and other activities needed to preserve the asset so that it continues to provide acceptable service. Other factors under consideration are whether the asset meets applicable building codes, and achieves its expected life. Maintenance and repairs do not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance and repair expenses are recognized as incurred.

CDC, NIH, and FDA all use the condition assessment survey for all classes of property. IHS uses two methods to assess installations – annual general inspections and facility condition surveys. The landholding OpDivs prioritize their maintenance activities based on urgency and the best use of their limited resources, with life safety the top priority. Deferred maintenance and repairs have been reported for all active and inactive assets; excess buildings and structures that are slated for disposal or demolition are not included. For buildings, equipment, and other structures, acceptable condition is defined in accordance with standards comparable to those used in private industry. For example, factors can include Property, Plant and Equipment location, age, design etc. Prior year numbers have been adjusted to conform to SFFAS No. 42 and the current year presentation.

Category of Asset	Estimated Cost to Return to Acceptable Condition (in Millions)	
	2016	2015
General Property, Plant and Equipment		
Buildings	\$ 2,068	\$ 2,216
Equipment	13	13
Other Structures	25	21
<b>Total</b>	<b>\$ 2,106</b>	<b>\$ 2,250</b>

In a condition assessment survey, asset condition is assessed on a scale of 1-5 as follows: Excellent-1; Good-2; Fair-3; Poor-4; Very Poor-5. A “fair” or 3 rating is considered acceptable operating condition. Although Property, Plant and Equipment categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, asset categories with an overall rating of “fair” or above may still report necessary costs to return them to acceptable condition.

## Social Insurance

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for five decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The projections in this year's report are based on current law and include the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA; Public Law 114-10), which repealed the sustainable growth rate (SGR) formula that set physician fee schedule payments. While the physician payment updates and new incentives put in place by MACRA avoid the significant short-range physician payment issues that would have resulted from the SGR system approach, they nevertheless raise important long-range concerns. In particular, additional payments of \$500 million per year for one group of physicians and 5 percent annual bonuses for another group are scheduled to expire in 2025, resulting in a significant one-time payment reduction for most physicians. In addition, the law specifies the physician payment update amounts for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The gap will continue to widen throughout the projection period, and the Trustees anticipate that physician payment rates under current law will be lower than they would have been under the SGR formula by 2048. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term under current law.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012* (Public Law 112-240, enacted on January 2, 2013); the *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; the *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014); and the *Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2025 and by 4 percent from April 1, 2025 through September 30, 2025. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2025.

These projections also incorporate the effects of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*. This legislation, referred to collectively as the *Affordable Care Act*, contains roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving benefits, combating fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the *Affordable Care Act* and MACRA that lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. It is conceivable that providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. The current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the *Affordable Care Act* -mandated reductions in other Medicare payment rates. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes legislative changes that result in (i) physician payment updates that transition from the 0 percent update specified in current law for 2025 to the rate of growth in the Medicare Economic Index of 2.2 percent for 2040 and later; (ii) no expiration of the 5 percent bonuses for physicians in alternative payment models; (iii) a partial phase-out of the *Affordable Care Act* reductions in Medicare payment rates from 2020 through 2034; and (iv) an elimination of the cost-reducing actions of the Independent Payment Advisory Board (IPAB). The difference between the illustrative alternative and the current-law projections demonstrates that the long-range costs could be substantially higher than shown throughout much of the report if the MACRA<sup>12</sup> and *Affordable Care Act*<sup>13</sup> cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 25 in these financial statements, in appendix V.C of this year's annual Medicare Trustees Report, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from [www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds).

<sup>12</sup> Under MACRA, a significant one-time payment reduction is scheduled for most physicians in 2025. In addition, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.2 percent per year in the long range.

<sup>13</sup> Under the *Affordable Care Act*, Medicare's annual payment rate updates for most categories of provider services would be reduced below the increase in providers' input prices by the growth in economy-wide private nonfarm business multifactor productivity (1.1 percent over the long range). In addition, the IPAB would be charged with recommending cost savings as are necessary to hold overall per capita Medicare growth to the average of the Consumer Price Index for all Urban Consumers (CPI-U) and CPI-medical care increases in 2015-2019 and to the rate of per capita GDP growth plus 1 percentage point thereafter (subject to certain limits). Unless overridden by lawmakers, these recommendations would be implemented automatically.

## Actuarial Projections

### Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is based on statutory price updates and volume and intensity growth derived from the “factors contributing to growth” model, which decomposes the major drivers of historical and projected health spending growth into distinct factors. The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection. The Trustees’ methodology is consistent with Finding III-2 and Recommendation III-2 of the 2010-2011 Medicare Technical Review Panel.<sup>14</sup>

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the longstanding Gross Domestic Product (GDP) plus 1 percent assumption while incorporating several key refinements (Recommendation III-1).<sup>15</sup> Specifically, the Panel recommended two separate means of establishing long-range growth rates:

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the *Affordable Care Act*) compared to private health insurance and other payers of health care in the U.S. This refinement results in an increase in the long-range pre-*Affordable Care Act* baseline cost growth assumption for Medicare to GDP plus 1.4 percent.
- The “factors contributing to growth” model approach builds upon the key considerations underlying the earlier GDP plus 1 percent assumption. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.<sup>16</sup> It benefits from additional information that was not available when the 2000 Technical Panel recommended the GDP plus 1 percent assumption.

The Trustees used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010-2011 Technical Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

Prior to the *Affordable Care Act*, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers’ input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to

<sup>14</sup>The Panel’s final report is available at [www.aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf](http://www.aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf).

<sup>15</sup> For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate. Similarly, these growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

<sup>16</sup> Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. “Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?” *Health Affairs*, 28, no. 5 (2009): 1276-1284.

## REQUIRED SUPPLEMENTARY INFORMATION

produce the health care goods and services.<sup>17</sup> To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the *Affordable Care Act* were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall. The *Affordable Care Act* requires that many of these Medicare payment updates be reduced by the 10 year moving average increase in economy-wide private nonfarm business multifactor productivity,<sup>18</sup> which the Trustees assume will be 1.1 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of health care provider services:

**(i) All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.**

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year per capita increases for these provider services start at 3.9 percent in 2040, or GDP plus 0.0 percent, declining gradually to 3.5 percent in 2090, or GDP minus 0.3 percent.<sup>19</sup>

**(ii) Physician services**

Payment rate updates are 0.75 percent per year for those physicians assumed to be participating in alternative payment models and 0.25 percent for those assumed to be participating in the merit-based incentive payment system. The year-by-year per capita growth rates for physician payments are assumed to be 3.6 percent in 2040, or GDP minus 0.3 percent, declining to 2.8 percent in 2090, or GDP minus 1.0 percent.

**(iii) Certain SMI Part B services that are updated annually by the Consumer Price Index (CPI) increase less the increase in economy-wide productivity.**

Such services include durable medical equipment,<sup>20</sup> care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.1 percent in 2040, or GDP minus 0.8 percent, declining to 2.7 percent in 2090, or GDP minus 1.1 percent.

**(iv) All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services.**

These Part B outlays constitute an estimated 15 percent of total Part B expenditures in 2025 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.<sup>21</sup> The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year per capita growth rates for these services are 4.8 percent in 2040, or GDP plus 0.9 percent, declining to 4.3 percent by 2090, or GDP plus 0.5 percent.

<sup>17</sup> Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices. The law did not specify any such adjustments after 2009.

<sup>18</sup> For convenience the term *economy-wide private nonfarm business multifactor productivity* will henceforth be referred to as *economy-wide productivity*.

<sup>19</sup> These growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent

<sup>20</sup> Certain durable medical equipment (DME) is subject to competitive bidding, and the price is assumed to grow by the CPI increase less the increase in economy-wide productivity, the same update specified for DME not subject to bidding.

<sup>21</sup> For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.



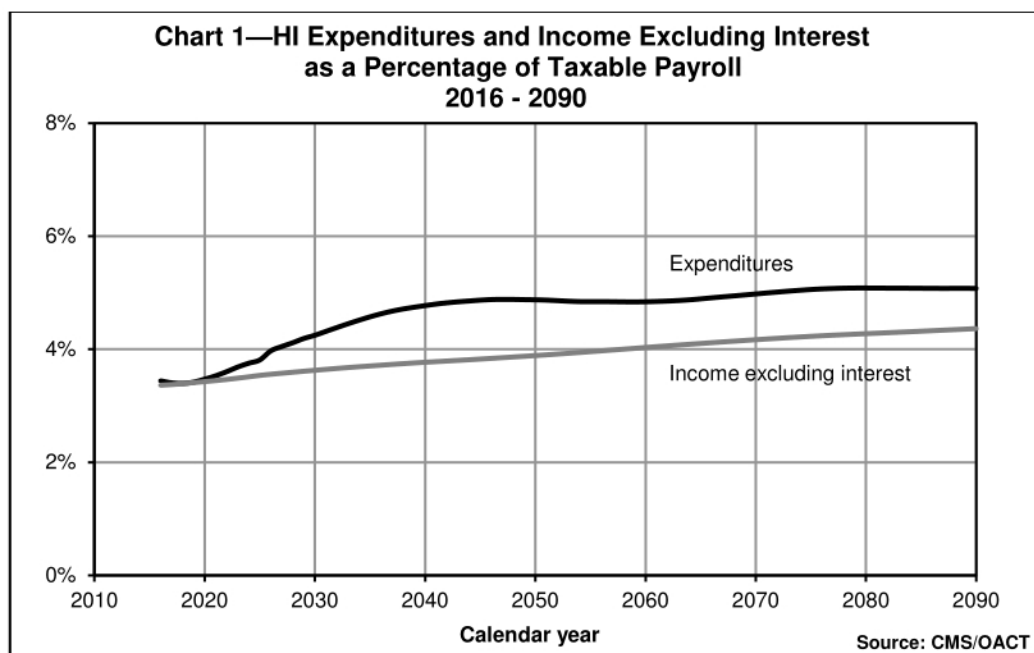
In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the four long-range assumptions, the weighted average growth rate for Part B is 3.6 percent per year for the last 50 years of the projection period, or GDP minus 0.3 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 3.8 percent over this same time period or GDP minus 0.1 percent, while the growth rate in 2090 is 3.6 percent or GDP minus 0.2 percent.

## HI Cashflow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll).

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI income and cost rates shown in the 2016 report are higher than those from the 2015 report for all years primarily due to the inclusion of the income and costs for the uninsured beneficiaries. Without the inclusion of these income and cost amounts, the income rate would have been slightly lower for the entire projection period, and the cost rate would have been slightly higher initially (due to the increased hospital utilization) but would have eventually become slightly lower by 2040.



Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, starting in 2013, high-income workers pay an additional 0.9 percent of their earnings above \$200,000 (for single workers) or \$250,000 (for married couples filing joint income tax returns). Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and

consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

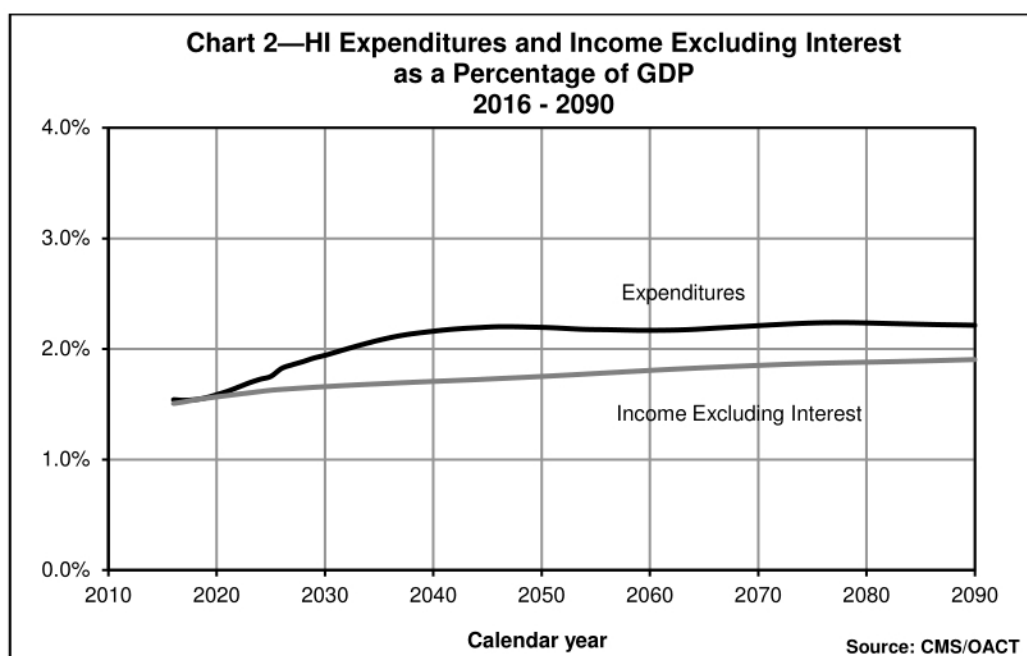
As indicated in Chart 1, the cost rate is projected to decline through 2018, largely due to (i) expenditure growth that was constrained in part by the sequester and low payment updates and (ii) a rebound of taxable payroll growth from 2007-2009 recession levels. After 2018 the cost rate is projected to rise primarily due to retirements of those in the baby boom generation and partly due to a projected return to modest health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.9 percent through 2025 and 1.1 percent thereafter. Under the illustrative alternative scenario, if the slower price updates were not feasible in the long range and were phased down during 2020-2034, then the HI cost rate would be 4.9 percent in 2035 and 8.4 percent in 2090. These levels are about 8 percent and 65 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

### HI and SMI Cashflow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

#### HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2015, the expenditures were \$278.9 billion, which was 1.6 percent of GDP. This percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.6 percent in 2090.

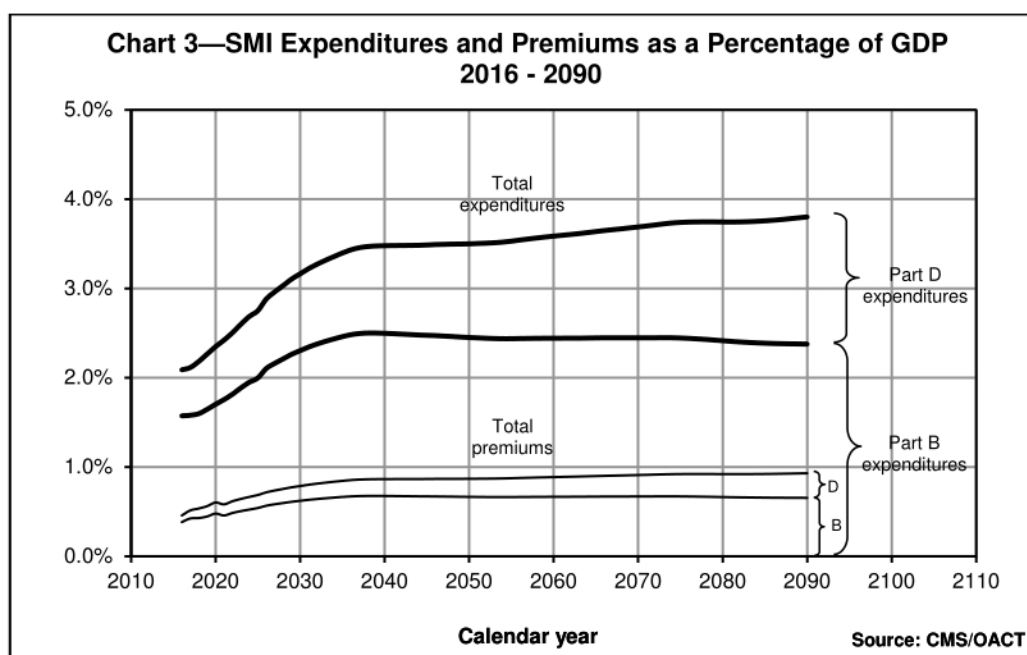


# SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long range assumption described previously.

In 2015, SMI expenditures were \$368.8 billion, or about 2.1 percent of GDP. Under current law, they would grow to about 3.5 percent of GDP within 25 years and to 3.8 percent by the end of the projection period. (Under the illustrative alternative, total SMI expenditures in 2090 would be 5.4 percent of GDP.)

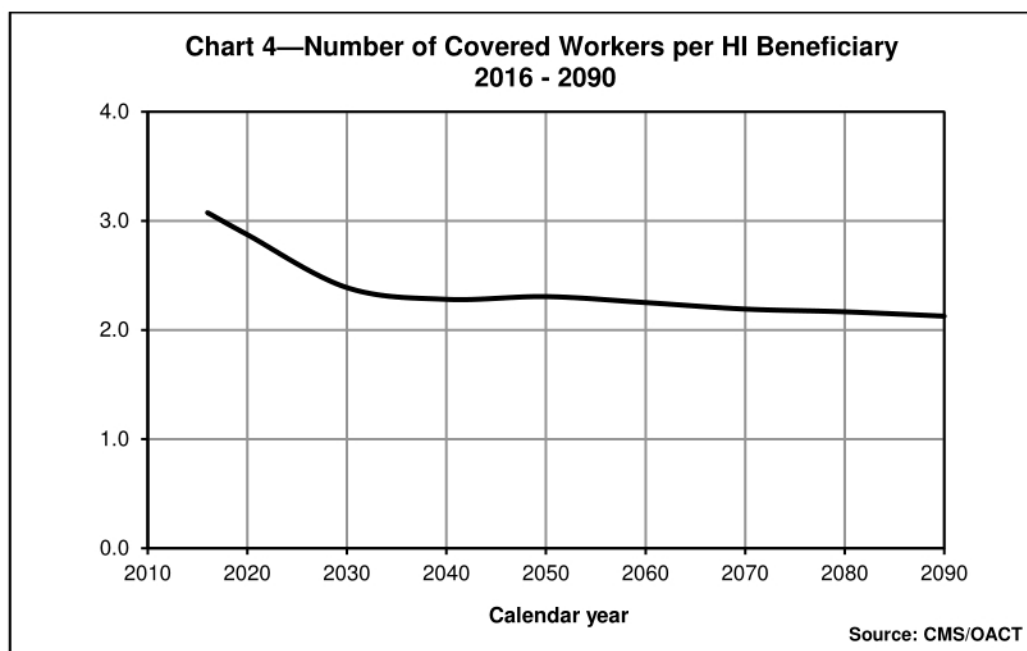


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2015 by about 4.2 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

## Worker-to-Beneficiary Ratio

### HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation. In 2015, every beneficiary had 3.1 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2090.



### Sensitivity Analysis

To prepare projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.<sup>22</sup> The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.<sup>23</sup>

<sup>22</sup>Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.

<sup>23</sup>The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

For this analysis, the intermediate economic and demographic assumptions in the *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2016 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values initially increase, as the effects of the *Affordable Care Act* result in trust fund surpluses, and then decrease through the first 25 to 30 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

### Health Care Cost Factors

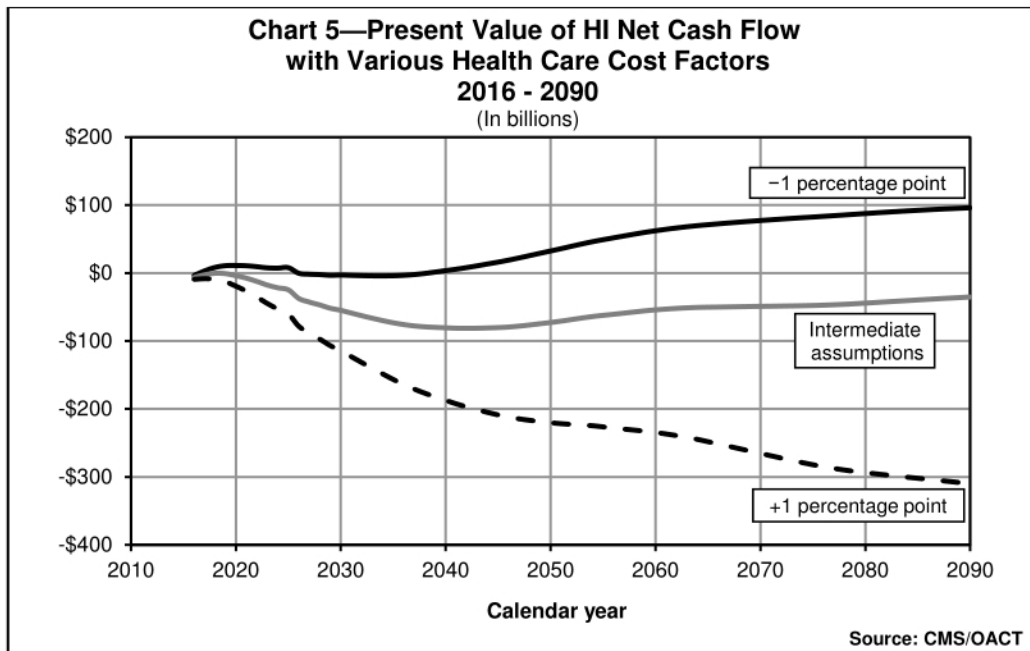
Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as assumed for the intermediate assumptions.

**Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions**

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	\$3,198	-\$3,822	-\$15,054

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by \$7,020 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by \$11,232 billion.

Chart 5 shows projections of the present value of the estimated net cash flow under the three alternative annual growth rate assumptions presented in Table 1.



This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus due to the improved financial outlook for the HI trust fund as a result of the *Affordable Care Act*. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

### Real-Wage Differential

Table 2 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.<sup>24</sup> In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.4 percent, respectively.

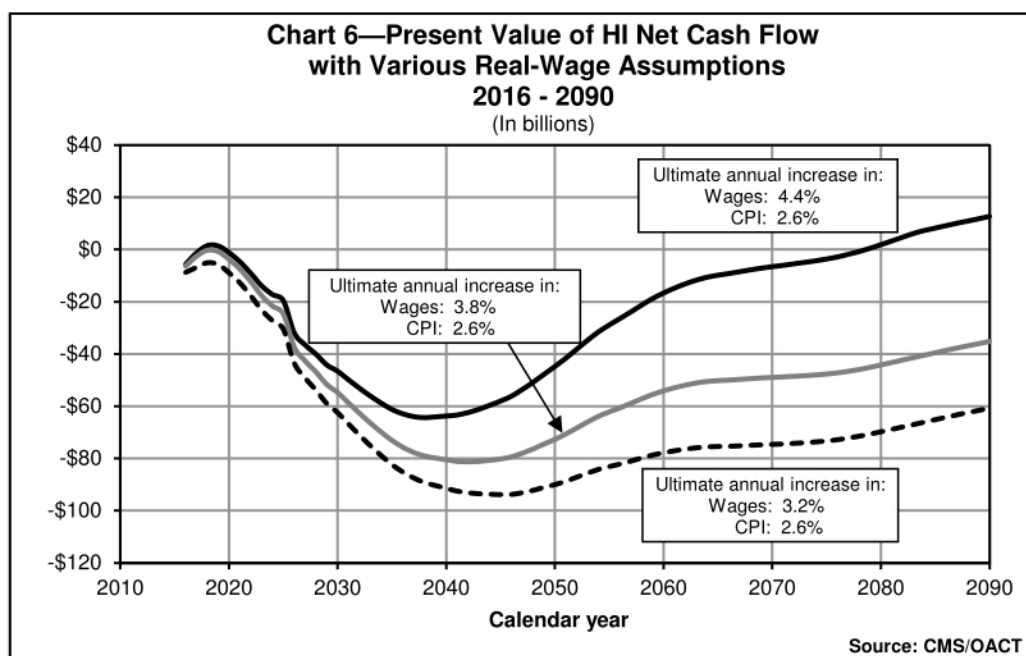
**Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions**

Ultimate percentage increase in wages – CPI	3.2 – 2.6	3.8 – 2.6	4.4 – 2.6
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures (in billions)	–\$5,116	–\$3,822	–\$1,748

<sup>24</sup>The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately \$1,730 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about \$1,080 billion.

Chart 6 shows projections of the present value of the estimated net cash flow under the three alternative real-wage differential assumptions presented in Table 2.



As illustrated in Chart 6, faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the *Affordable Care Act* and MACRA depends critically on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. Sustaining these price reductions will be challenging for health care providers, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services.

## Consumer Price Index

**Table 3—Present Value of Estimated HI Income  
Less Expenditures under Various CPI-Increase Assumptions**

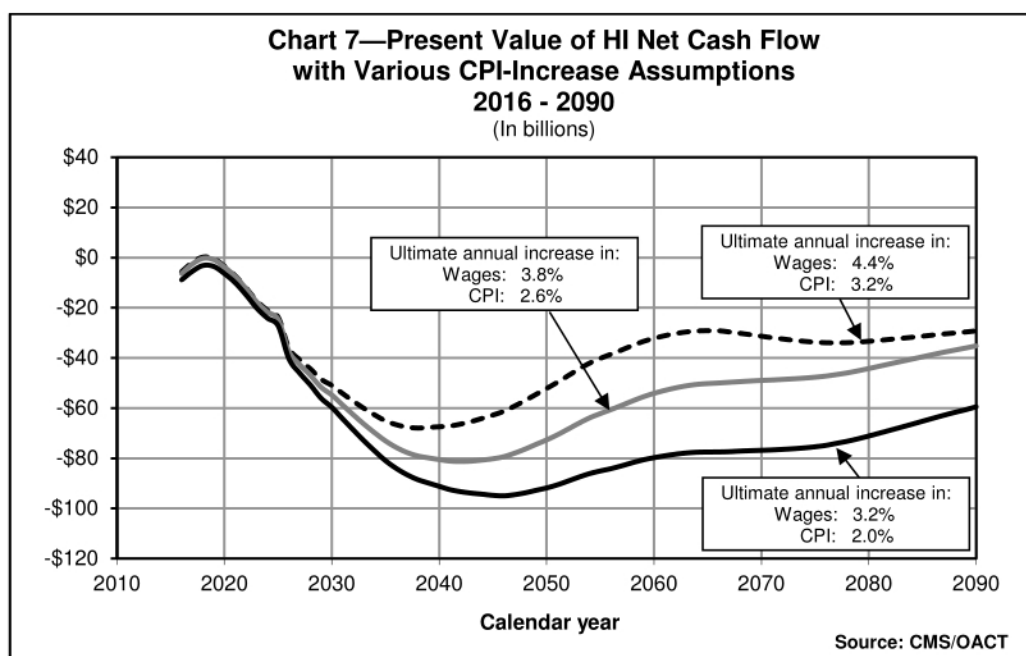
Ultimate percentage increase in wages – CPI	4.4 – 3.2	3.8 – 2.6	3.2 – 2.0
Income minus expenditures (in billions)	–\$2,902	–\$3,822	–\$5,133

## REQUIRED SUPPLEMENTARY INFORMATION

Table 3 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.2, 2.6, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.2 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.4, 3.8, and 3.2 percent, respectively.

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.2 percent, the deficit decreases by \$920 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by \$1,311 billion.

Chart 7 shows projections of the present value of net cash flow under the three alternative CPI rate-of-increase assumptions presented in Table 3.



As Chart 7 indicates, this assumption has a small impact when the cash flow is expressed as present values. The relative insensitivity of the projected present values of HI cash flow to different levels of general inflation occurs because inflation tends to proportionately affect both income and costs in a similar manner. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required by the *Affordable Care Act* for workers with earnings above \$200,000 or \$250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

### Real-Interest Rate

Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.2, 2.7, and 3.2 percent. In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, which results in ultimate annual yields of 4.8, 5.3, and 5.8 percent, respectively.

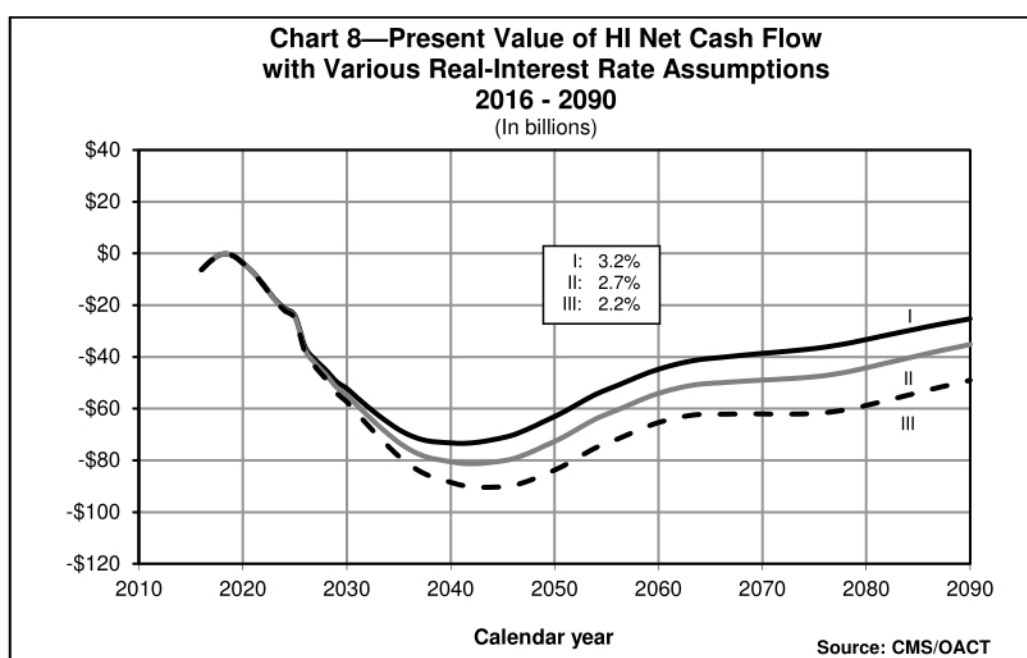


**Table 4—Present Value of Estimated HI Income  
Less Expenditures under Various Real-Interest Assumptions**

Ultimate real-interest rate	2.2 percent	2.7 percent	3.2 percent
Income minus expenditures (in billions)	-\$4,505	-\$3,822	-\$2,266

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately \$125 billion.

Chart 8 shows projections of the present value of the estimated net cash flow under the three alternative real-interest assumptions presented in Table 4.



As shown in Chart 8, the projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2028. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

## Fertility Rate

Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.8, 2.0, and 2.2 children per woman.

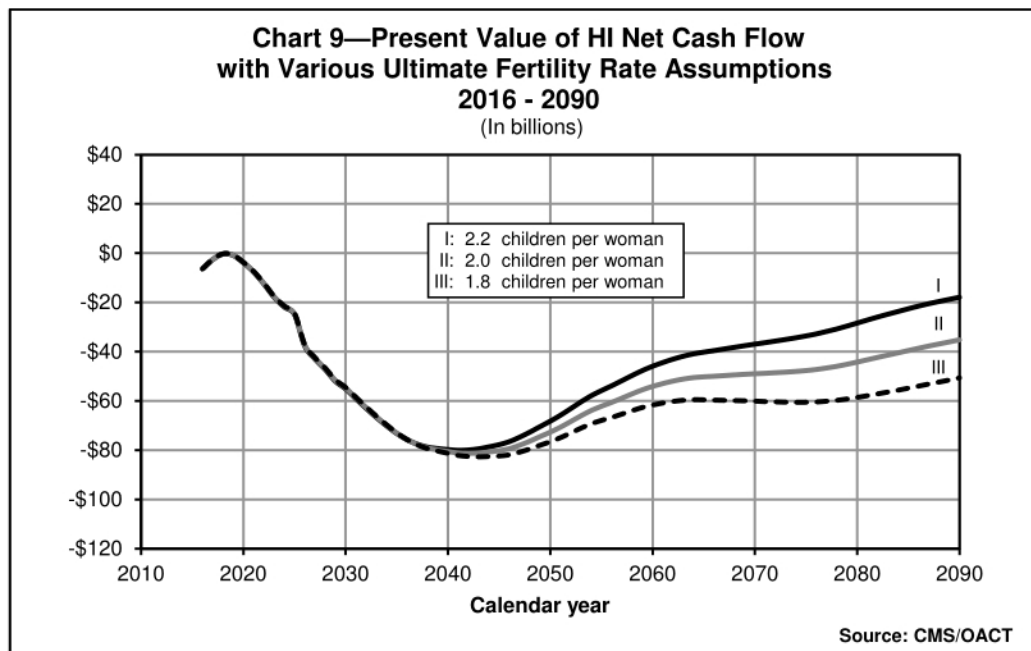
**Table 5—Present Value of Estimated HI Income  
Less Expenditures under Various Fertility Rate Assumptions**

Ultimate fertility rate <sup>1</sup>	1.8	2.0	2.2
Income minus expenditures (in billions)	-\$4,280	-\$3,822	-\$3,318

<sup>1</sup>The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As Table 5 demonstrates, for an increase of 0.2 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately \$480 billion.

Chart 9 shows projections of the present value of the net cash flow under the three alternative fertility rate assumptions presented in Table 5.



As Chart 9 indicates, the fertility rate assumption has a substantial impact on projected HI cash flows. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, and many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. On the other hand, under the lower fertility rate assumptions, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

## Net Immigration

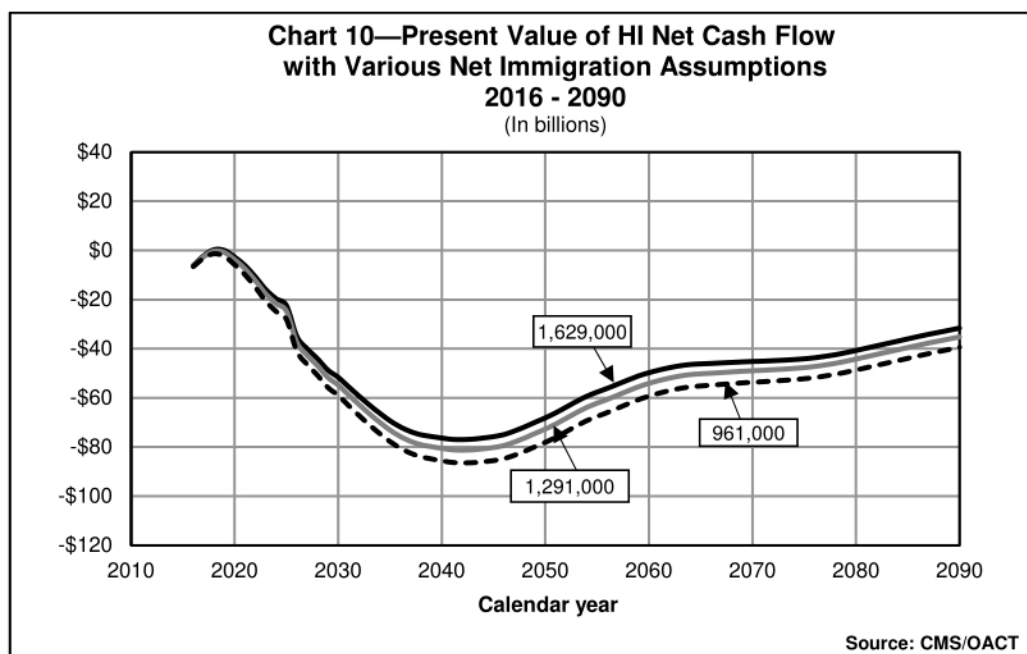
Table 6 shows the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 961,000 persons, 1,291,000 persons, and 1,629,000 persons per year.

**Table 6—Present Value of Estimated HI Income  
Less Expenditures under Various Net Immigration Assumptions**

Average annual net immigration	961,000	1,291,000	1,629,000
Income minus expenditures (in billions)	-\$4,153	-\$3,822	-\$3,558

As indicated in Table 6, if the average annual net immigration assumption is 961,000 persons, the deficit—expressed in present-value dollars—increases by \$331 billion. Conversely, if the assumption is 1,629,000 persons, the deficit decreases by \$264 billion.

Chart 10 shows projections of the present value of net cash flow under the three alternative average annual net immigration assumptions presented in Table 6.



Higher net immigration results in smaller HI cash flow deficits, as illustrated in Chart 10. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

## Trust Fund Finances and Sustainability

### *HI*

The short-range financial outlook for the HI trust fund has worsened as compared to the projections in last year's annual report. Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI trust fund is 2028, 2 years earlier than in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI tax income and expenditures are projected to be lower than last year's estimates, mostly due to lower CPI assumptions. The impact on expenditures is mitigated by lower productivity increases.

HI expenditures have exceeded income annually since 2008. However, the Trustees project slight surpluses in 2016 through 2020, with a return to deficits thereafter until the trust fund becomes depleted in 2028. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policy makers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

### *SMI*

The SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no provision in the law for transferring assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2016 is adequate to cover 2016 expected expenditures.<sup>25</sup> Similarly, Part D income and outgo would remain in balance as a result of the annual adjustment of premium and general revenue income to cover costs. The appropriation for Part D general revenues has generally been set such that amounts can be transferred to the Part D account on an as-needed basis.

The Part B and Part D accounts in the SMI trust fund are adequately financed because premium and general revenue income are reset each year to cover expected costs. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

### *Medicare Overall*

The law requires the Board of Trustees to determine whether the difference between Medicare outlays and dedicated financing sources<sup>26</sup> is projected to exceed 45 percent of total Medicare outlays under current law within

<sup>25</sup> A hold-harmless provision restricts Part B premium increases for most beneficiaries in 2016. The Bipartisan Budget Act of 2015 required that the 2016 monthly Part B premium be calculated as if the hold-harmless provision did not apply. However, it is required a transfer of funds from the general fund to cover the premium income that is lost as a result of the provision. In 2017 there may be a substantial increase in the Part B premium rate for some beneficiaries.

<sup>26</sup> Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

the next 7 fiscal years (2016-2022). If this level is attained within the 7-year timeframe, Federal law requires a determination of projected excess general revenue Medicare funding. For the 2016 Medicare Trustees Report, this difference is not expected to exceed 45 percent of total expenditures in fiscal years 2016-2022 (the first 7 years of the projection), and therefore the Trustees are not issuing this determination.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then these further policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2016 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of such reforms should not be delayed."



## Other Information

# 3

### In This Section

- Other Financial Information
- Freeze the Footprint
- Civil Monetary Penalty Adjustment for Inflation
- Improper Payments Information Act Report
- Summary of Financial Statement Audit and Management Assurances
- FY 2016 Top Management and Performance Challenges Identified by the Office of Inspector General
- Department's Response to the Office of the Inspector General Top Management and Performance Challenges

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## OTHER FINANCIAL INFORMATION

## Consolidating Balance Sheet by Budget Function

As of September 30, 2016

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
<b>Assets (Note 2)</b>							
<b>Intragovernmental Assets</b>							
Fund Balance with Treasury (Note 3)	\$ 10,339	\$ 158,539	\$ 53,806	\$ 15,075	\$ 237,759	\$ -	\$ 237,759
Investments, Net (Note 4)	-	4,276	257,801	-	262,077	-	262,077
Accounts Receivable, Net (Note 5)	159	3,792	73,925	5	77,881	(76,869)	1,012
Advances (Note 8)	16	290	28	31	365	(126)	239
<b>Total Intragovernmental Assets</b>	<b>10,514</b>	<b>166,897</b>	<b>385,560</b>	<b>15,111</b>	<b>578,082</b>	<b>(76,995)</b>	<b>501,087</b>
Accounts Receivable, Net (Note 5)	-	16,679	7,453	71	24,203	-	24,203
Inventory and Related Property, Net (Note 6)	-	9,399	-	-	9,399	-	9,399
General Property, Plant and Equipment, Net (Note 7)	-	5,415	250	-	5,665	-	5,665
Advances (Note 8)	-	20	21,460	-	21,480	-	21,480
Other Assets	-	819	-	-	819	-	819
<b>Total Assets</b>	<b>\$ 10,514</b>	<b>\$ 199,229</b>	<b>\$ 414,723</b>	<b>\$ 15,182</b>	<b>\$ 639,648</b>	<b>\$ (76,995)</b>	<b>\$ 562,653</b>
<b>Stewardship Land (Notes 1 and 20)</b>							
<b>Liabilities (Note 9)</b>							
<b>Intragovernmental Liabilities</b>							
Accounts Payable	\$ 18	\$ 321	\$ 76,738	\$ 1	\$ 77,078	\$ (76,739)	\$ 339
Other Liabilities (Note 13)	2	3,948	3,299	70	7,319	(256)	7,063
<b>Total Intragovernmental Liabilities</b>	<b>20</b>	<b>4,269</b>	<b>80,037</b>	<b>71</b>	<b>84,397</b>	<b>(76,995)</b>	<b>7,402</b>
Accounts Payable	17	761	193	10	981	-	981
Entitlement Benefits Due and Payable (Note 10)	-	44,319	63,911	-	108,230	-	108,230
Accrued Liabilities (Note 12)	955	12,437	(55)	1,083	14,420	-	14,420
Federal Employee and Veterans Benefits (Note 11)	4	12,879	9	-	12,892	-	12,892
Contingencies and Commitments (Note 14)	-	11,734	660	-	12,394	-	12,394
Other Liabilities (Note 13)	19	3,570	1,366	8	4,963	-	4,963
<b>Total Liabilities</b>	<b>1,015</b>	<b>89,969</b>	<b>146,121</b>	<b>1,172</b>	<b>238,277</b>	<b>(76,995)</b>	<b>161,282</b>
<b>Net Position</b>							
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	-	(100)	36,012	-	35,912	-	35,912
Unexpended Appropriations - Other funds	9,414	104,726	-	13,989	128,129	-	128,129
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	-	880	232,590	-	233,470	-	233,470
Cumulative Results of Operations - Other funds	85	3,754	-	21	3,860	-	3,860
<b>Total Net Position - Funds from Dedicated Collections</b>	<b>-</b>	<b>780</b>	<b>268,602</b>	<b>-</b>	<b>269,382</b>	<b>-</b>	<b>269,382</b>
<b>Total Net Position - Other Funds</b>	<b>9,499</b>	<b>108,480</b>	<b>-</b>	<b>14,010</b>	<b>131,989</b>	<b>-</b>	<b>131,989</b>
<b>Total Net Position</b>	<b>9,499</b>	<b>109,260</b>	<b>268,602</b>	<b>14,010</b>	<b>401,371</b>	<b>-</b>	<b>401,371</b>
<b>Total Liabilities and Net Position</b>	<b>\$ 10,514</b>	<b>\$ 199,229</b>	<b>\$ 414,723</b>	<b>\$ 15,182</b>	<b>\$ 639,648</b>	<b>\$ (76,995)</b>	<b>\$ 562,653</b>



## OTHER FINANCIAL INFORMATION

**Consolidating Statement of Net Cost by Budget Function**

For the Year Ended September 30, 2016

(in Millions)

Intra-HHS Eliminations

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Cost (-)	Revenue	Consolidated Totals
ACF	\$ 12,866	\$ -	\$ -	\$ 38,678	\$ 51,544	\$ (75)	\$ 7	\$ 51,476
ACL	2,059	-	-	-	2,059	(10)	8	2,057
AHRQ	-	282	-	-	282	(12)	78	348
CDC	-	11,922	-	-	11,922	(136)	118	11,904
CMS	-	386,946	566,114	-	953,060	(422)	13	952,651
FDA	-	2,818	-	-	2,818	(270)	14	2,562
HRSA	-	10,423	-	-	10,423	(277)	25	10,171
IHS	-	4,939	-	-	4,939	(192)	199	4,946
NIH	-	30,004	-	-	30,004	(327)	344	30,021
OS	-	3,122	-	-	3,122	(503)	485	3,104
PSC	-	1,354	-	-	1,354	(81)	630	1,903
SAMHSA	-	3,539	-	-	3,539	(33)	123	3,629
Net Cost of Operations	\$ 14,925	\$ 455,349	\$ 566,114	\$ 38,678	\$ 1,075,066	\$ (2,338)	\$ 2,044	\$ 1,074,772

**Gross Cost and Exchange Revenue**

For the Year Ended September 30, 2016

(in Millions)

Responsibility Segments	Intragovernmental						With the Public		Consolidated Net Cost of Operations
	Gross Cost			Less: Exchange Revenue			Gross Cost	Less: Exchange Revenue	
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated			
ACF	\$ 170	\$ (75)	\$ 95	\$ (15)	\$ 7	\$ (8)	\$ 51,420	\$ (31)	\$ 51,476
ACL	22	(10)	12	(9)	8	(1)	2,046	-	2,057
AHRQ	44	(12)	32	(78)	78	-	316	-	348
CDC	805	(136)	669	(272)	118	(154)	11,429	(40)	11,904
CMS	1,213	(422)	791	(33)	13	(20)	1,043,824	(91,944)	952,651
FDA	1,271	(270)	1,001	(33)	14	(19)	3,616	(2,036)	2,562
HRSA	370	(277)	93	(25)	25	-	10,130	(52)	10,171
IHS	712	(192)	520	(238)	199	(39)	5,684	(1,219)	4,946
NIH	1,366	(327)	1,039	(422)	344	(78)	29,751	(691)	30,021
OS	937	(503)	434	(517)	485	(32)	2,742	(40)	3,104
PSC	327	(81)	246	(1,237)	630	(607)	2,270	(6)	1,903
SAMHSA	70	(33)	37	(130)	123	(7)	3,599	-	3,629
Totals	\$ 7,307	\$ (2,338)	\$ 4,969	\$ (3,009)	\$ 2,044	\$ (965)	\$ 1,166,827	\$ (96,059)	\$ 1,074,772

## OTHER FINANCIAL INFORMATION

## Combined Schedule of Spending By Object Class

As of September 30, 2016

(in Millions)

The Combined Schedule of Spending presented below includes the United States (U.S.) Department of Health and Human Services' (HHS) spending for all Treasury Account Symbols with spending greater than \$1.0 billion to increase transparency.

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Financial Assistance Direct Payments	Other Contractual Services	Personnel Compensation & Benefits	Other	FY 2016
Medicaid	\$ 393,919	\$ -	\$ 108	\$ 18	\$ 4,172	\$ 398,217
Payments to Trust Funds	215,830	-	-	-	94,282	310,112
Federal Supplementary Medical Insurance Trust Fund	-	300,768	126	-	5,668	306,562
Federal Hospital Insurance Trust Fund	-	291,252	2	-	5,594	296,848
Medicare Prescription Drug Account	-	92,039	-	-	765	92,804
Taxation on OASDI Benefits, HI	23,022	-	-	-	-	23,022
Temporary Assistance for Needy Families	16,649	-	71	2	-	16,722
State Children's Health Insurance Fund	14,002	-	4	-	64	14,070
Children and Families Services Programs	10,509	-	291	151	24	10,975
Payments for Foster Care and Permanency	7,822	-	35	-	1	7,858
Transitional Reinsurance Program	-	7,842	-	-	4	7,846
National Cancer Institute	3,300	-	1,457	511	124	5,392
Indian Health Services	2,339	-	847	1,361	703	5,250
Primary Health Care	4,733	-	232	64	12	5,041
National Institute of Allergy and Infectious Diseases	3,384	-	1,222	319	94	5,019
Payments to States for Child Support Enforcement and Family Support Programs	3,683	-	684	-	-	4,367
Risk Adjustment Program Payments	-	3,544	-	-	-	3,544
Low Income Home Energy Assistance	3,369	-	3	-	-	3,372
National Heart, Lung, and Blood Institute	2,465	-	525	158	35	3,183
Child Care Entitlement to States	2,928	-	23	-	-	2,951
Medicare Health Information Technology Incentive	-	2,794	-	-	-	2,794
Payment to States for the Child Care and Development Block Grant	2,719	-	42	-	-	2,761
National Institute of General Medical Sciences	2,442	-	83	31	1	2,557
Ryan White HIV/AIDS Program	2,149	-	92	24	4	2,269
Substance Abuse Treatment	2,045	-	144	9	2	2,200
Aging and Disability Services Programs	1,956	-	47	29	4	2,036
National Institute of Diabetes and Digestive and Kidney Diseases	1,662	-	218	116	22	2,018
Health Care Fraud and Abuse Control Account	-	-	1,267	74	533	1,874
Refugee and Entrant Assistance	1,502	-	346	13	4	1,865
Public Health and Social Services Emergency Fund	348	-	853	122	478	1,801
Service and Supply Fund	46	-	1,108	264	352	1,770
National Institute of Neurological Disorders and Stroke	1,416	-	215	89	31	1,751
Social Services Block Grant	1,657	-	10	1	-	1,668
National Institute on Aging	1,383	-	154	71	25	1,633
National Institute of Mental Health	1,261	-	206	95	16	1,578
State Grants and Demonstration	1,480	1	80	11	1	1,573
National Institute of Child Health and Human Development	982	-	311	99	18	1,410
Public Health Preparedness and Response	613	-	300	110	350	1,373
HHS Service and Supply Fund	-	-	1,108	149	96	1,353
Centers for Medicare and Medicaid Innovation	464	109	645	74	3	1,295
Mental Health	1,069	-	118	4	3	1,194
CDC-Wide Activities and Program Support	518	-	367	179	121	1,185
Chronic Disease Prevention and Health Promotion	762	-	283	127	7	1,179
National Institute on Drug Abuse	864	-	194	66	9	1,133
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention	738	-	200	171	14	1,123
Other Agency Budgetary Accounts	13,129	5,696	12,941	6,803	2,686	41,255
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 749,159</b>	<b>\$ 704,045</b>	<b>\$ 26,962</b>	<b>\$ 11,315</b>	<b>\$ 116,322</b>	<b>\$ 1,607,803</b>

## OTHER FINANCIAL INFORMATION

## Combined Schedule of Spending By Object Class

As of September 30, 2015

(in Millions)

The Combined Schedule of Spending presented below includes HHS's spending for all Treasury Account Symbols with spending greater than \$1.0 billion to increase transparency.

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Financial Assistance Direct Payments	Other Contractual Services	Personnel Compensation & Benefits	Other	FY 2015
Medicaid	\$ 375,142	\$ -	\$ 101	\$ 17	\$ 3,637	\$ 378,897
Payments to Trust Funds	195,385	72	-	-	67,445	262,902
Federal Supplementary Medical Insurance Trust Fund	-	276,841	44	-	4,755	281,640
Federal Hospital Insurance Trust Fund	-	277,001	2	-	8,071	285,074
Medicare Prescription Drug Account	-	80,429	-	-	154	80,583
Taxation on OASDI Benefits, HI	20,208	-	-	-	-	20,208
Temporary Assistance for Needy Families	16,657	-	58	2	-	16,717
State Children's Health Insurance Fund	11,486	-	4	-	6	11,496
Children and Families Services Programs	10,121	-	262	143	19	10,545
Payments for Foster Care and Permanency	7,360	-	26	-	1	7,387
Transitional Reinsurance Program	-	8,249	-	-	-	8,249
National Cancer Institute	3,609	-	1,178	504	95	5,386
Indian Health Services	2,834	-	803	1,332	733	5,702
Primary Health Care	4,449	-	200	41	10	4,700
National Institute of Allergy and Infectious Diseases	3,043	-	1,492	310	83	4,928
Payments to States for Child Support Enforcement and Family Support Programs	3,637	-	710	-	-	4,347
Risk Adjustment Program Payments	-	2,141	-	-	-	2,141
Low Income Home Energy Assistance	3,392	-	3	-	-	3,395
National Heart, Lung, and Blood Institute	2,237	-	551	152	33	2,973
Child Care Entitlement to States	2,929	-	17	-	-	2,946
Medicare Health Information Technology Incentive	-	4,282	-	-	-	4,282
Payment to States for the Child Care and Development Block Grant	2,396	-	39	-	-	2,435
National Institute of General Medical Sciences	2,141	-	103	29	2	2,275
Ryan White HIV/AIDS Program	2,199	-	83	27	9	2,318
Substance Abuse Treatment	2,024	-	146	10	7	2,187
Aging and Disability Services Programs	1,850	-	35	27	4	1,916
National Institute of Diabetes and Digestive and Kidney Diseases	1,417	-	206	112	23	1,758
Health Care Fraud and Abuse Control Account	-	-	1,775	55	7	1,837
Refugee and Entrant Assistance	1,247	-	137	10	4	1,398
Public Health and Social Services Emergency Fund	455	-	1,085	119	304	1,963
Service and Supply Fund	-	-	980	261	372	1,613
National Institute of Neurological Disorders and Stroke	1,205	-	207	85	22	1,519
Social Services Block Grant	1,648	-	11	1	-	1,660
National Institute on Aging	1,094	-	151	68	16	1,329
National Institute of Mental Health	1,036	-	206	93	16	1,351
State Grants and Demonstration	524	37	65	11	50	687
National Institute of Child Health and Human Development	961	-	313	98	20	1,392
Public Health Preparedness and Response	633	-	273	104	343	1,353
HHS Service and Supply Fund	-	-	974	150	98	1,222
Centers for Medicare and Medicaid Innovation	595	63	649	61	3	1,371
Mental Health	946	-	142	4	4	1,096
CDC-Wide Activities and Program Support	605	-	332	151	115	1,203
Chronic Disease Prevention and Health Promotion	764	-	301	128	8	1,201
National Institute on Drug Abuse	723	-	222	66	13	1,024
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention	751	-	185	166	16	1,118
Other Agency Budgetary Accounts	11,410	3,135	12,418	6,467	2,327	35,757
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 699,113</b>	<b>\$ 652,250</b>	<b>\$ 26,489</b>	<b>\$ 10,804</b>	<b>\$ 88,825</b>	<b>\$ 1,477,481</b>

## FREEZE THE FOOTPRINT

For the Year Ended September 30, 2016

Freeze the Footprint Baseline Comparison (in Square Footage)			
	2012 Baseline	2015 Year End	+/- Change
Total Leased	13,603,974	14,068,529	464,555
Total Owned	6,112,229	6,278,246	166,017
<b>Total</b>	<b>19,716,203</b>	<b>20,346,775</b>	<b>630,572</b>

Reporting of O&M Costs - Owned and Direct Lease Buildings (in Millions)			
	2012 Baseline	2015 Year End	+/- Change
Operation and Maintenance Costs	\$ 83.3	\$ 92.2	\$ 8.9

Per OMB Memorandum-12-12, *Promoting Efficient Spending to Support Agency Operations*, and OMB Management Procedures Memorandum 2013-02, the "Freeze the Footprint" implementing guidance, all *Chief Financial Officers Act of 1990* departments and agencies shall not increase the total square footage of their domestic office and warehouse inventory compared to the FY 2012 baseline.

Compared to the Fiscal Year (FY) 2012 Baseline, the FY 2015 HHS office and warehouse space inventory increased by 630,572 square feet or 3.0 percent; this happened because of known projects already underway and overlap between leases when relocating. This short term increase is consistent with the projections in the HHS Freeze the Footprint Plan. To reach this goal, HHS has aggressively pursued space and cost savings in office and warehouse space, implemented a 170 useable square feet per person policy, and targeted consolidation projects for both office and warehouse space.

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

On November 2, 2015, the President signed into law the *Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015* (the 2015 Act) (Sec. 701 of Public Law 114-74), which further amended the *Federal Civil Penalties Inflation Adjustment Act of 1990* (Public Law 104-410), to improve the effectiveness of civil monetary penalties and to maintain their deterrent effect. Agencies must report the most recent inflationary adjustments to civil monetary penalties in order to ensure penalty adjustments are both timely and accurate.

The 2015 Act applies to eight Operating Divisions (OpDivs) and Staff Divisions (StaffDivs): ACF, AHRQ, HRSA, FDA, CMS, Office for Civil Rights, Office of the General Counsel, and Office of Inspector General. The table below illustrates HHS's civil monetary penalties by OpDivs and StaffDivs. For more information on HHS's Civil Monetary Penalties, visit [www.federalregister.gov/documents/2016/09/06/2016-18680/adjustment-of-civil-monetary-penalties-for-inflation](http://www.federalregister.gov/documents/2016/09/06/2016-18680/adjustment-of-civil-monetary-penalties-for-inflation).

Administration for Children and Families				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for Misuse of Information in the National Directory of New Hires.	42 U.S.C. 653(l)(2)	1998	8/1/2016	\$ 1,450

Agency for Healthcare Research and Quality				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for an establishment or person supplying information obtained in the course of activities for any purpose other than the purpose for which it was supplied.	42 U.S.C. 299c—(3)(d)	1999	8/1/2016	\$ 14,140

Health Resources and Services Administration				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for each instance of overcharging a 340B covered entity.	42 U.S.C. 256b(d)(1)(B)(vi)	2010	8/1/2016	\$ 5,437

Office for Civil Rights				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for violation of confidentiality provision of the <i>Patient Safety and Quality Improvement Act</i> .	42 U.S.C. 299b-22(f)(1)	2005	8/1/2016	\$ 11,940
Penalty for each pre-February 18, 2009 violation of the HIPAA administrative simplification provisions.	42 U.S.C. 1320(d)-5(a)	1996	8/1/2016	150
Calendar Year Cap		1996	8/1/2016	37,561
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the covered entity or business associate did not know and by exercising reasonable diligence, would not have known that the covered entity or business associate violated such a provision.			8/1/2016	
Minimum		2009	8/1/2016	110
Maximum		2009	8/1/2016	55,010
Calendar Year Cap		2009	8/1/2016	1,650,300

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to reasonable cause and not to willful neglect.	42 U.S.C. 1320(d)-5(a)		8/1/2016	
Minimum		2009	8/1/2016	1100
Maximum		2009	8/1/2016	55,010
Calendar Year Cap		2009	8/1/2016	1,650,300
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to willful neglect and was corrected during the 30-day period beginning on the first date the covered entity or business associate knew, or, by exercising reasonable diligence, would have known that the violation occurred.			8/1/2016	
Minimum		2009	8/1/2016	11,002
Maximum		2009	8/1/2016	55,010
Calendar Year Cap		2009	8/1/2016	1,650,300
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to willful neglect and was not corrected during the 30-day period beginning on the first date the covered entity or business associate knew, or by exercising reasonable diligence, would have known that the violation occurred.			8/1/2016	
Minimum		2009	8/1/2016	55,010
Maximum		2009	8/1/2016	1,650,300
Calendar Year Cap		2009	8/1/2016	1,650,300

Office of the General Counsel				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for the first time an individual makes an expenditure prohibited by regulations regarding lobbying disclosure, absent aggravating circumstances.	31 U.S.C. 1352	1989	8/1/2016	\$ 18,936
Penalty for second and subsequent offenses by individuals who make an expenditure prohibited by regulations regarding lobbying disclosure.			8/1/2016	
Minimum		1989	8/1/2016	18,936
Maximum		1989	8/1/2016	189,361
Penalty for the first time an individual fails to file or amend a lobbying disclosure form, absent aggravating circumstances.		1989	8/1/2016	18,936
Penalty for second and subsequent offenses by individuals who fail to file or amend a lobbying disclosure form, absent aggravating circumstances.			8/1/2016	
Minimum		1989	8/1/2016	18,936
Maximum		1989	8/1/2016	189,361

# CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for failure to provide certification regarding lobbying in the award documents for all sub-awards of all tiers.	31 U.S.C. 1352		8/1/2016	
Minimum		1989	8/1/2016	18,936
Maximum		1989	8/1/2016	189,361
Penalty for failure to provide statement regarding lobbying for loan guarantee and loan insurance transactions.			8/1/2016	
Minimum		1989	8/1/2016	18,936
Maximum		1989	8/1/2016	189,361
Penalty against any individual who - with knowledge or reason to know - makes, presents or submits a false, fictitious or fraudulent claim to the Department	31 U.S.C. 3801-3812	1988	8/1/2016	9,894
Penalty against any individual who - with knowledge or reason to know - makes, presents or submits a false, fictitious or fraudulent claim to the Department		1988	8/1/2016	9,894

## Office of Inspector General

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for each individual who violates safety and security procedures related to handling dangerous biological agents and toxins.	42 U.S.C. 262a(i)(1)	2002	8/1/2016	\$ 327,962
Penalty for any other person who violates safety and security procedures related to handling dangerous biological agents and toxins.		2002	8/1/2016	655,925
Penalty for knowingly presenting or causing to be presented to an officer, employee, or agent of the United States a false claim.	42 U.S.C. 1320a-7a(a)	1996	8/1/2016	15,024
Penalty for knowingly presenting or causing to be presented a request for payment which violates the terms of an assignment, agreement, or PPS agreement.		1996	8/1/2016	15,024
Penalty for knowingly giving or causing to be presented to a participating provider or supplier false or misleading information that could reasonably be expected to influence a discharge decision.		1996	8/1/2016	22,537
Penalty for an excluded party retaining ownership or control interest in a participating entity.		1996	8/1/2016	15,024
Penalty for remuneration offered to induce program beneficiaries to use particular providers, practitioners, or suppliers.		1996	8/1/2016	15,024
Penalty for employing or contracting with an excluded individual.		1997	8/1/2016	14,718
Penalty for knowing and willful solicitation, receipt, offer, or payment of remuneration for referring an individual for a service or for purchasing, leasing, or ordering an item to be paid for by a Federal health care program.		1997	8/1/2016	73,588

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for ordering or prescribing medical or other item or service during a period in which the person was excluded.	42 U.S.C. 1320a-7a(a)	2010	8/1/2016	10,874
Penalty for knowingly making or causing to be made a false statement, omission or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider or supplier.		2010	8/1/2016	54,372
Penalty for knowing of an overpayment and failing to report and return.		2010	8/1/2016	10,874
Penalty for making or using a false record or statement that is material to a false or fraudulent claim		2010	8/1/2016	54,372
Penalty for failure to grant timely access to HHS OIG for audits, investigations, evaluations, and other statutory functions of HHS OIG.		2010	8/1/2016	16,312
Penalty for payments by a hospital or critical access hospital to induce a physician to reduce or limit services to individuals under direct care of physician or who are entitled to certain medical assistance benefits.	42 U.S.C. 1320a-7a(b)	1986	8/1/2016	4,313
Penalty for physicians who knowingly receive payments from a hospital or critical access hospital to induce such physician to reduce or limit services to individuals under direct care of physician or who are entitled to certain medical assistance benefits.		1986	8/1/2016	4,313
Penalty for a physician who executes a document that falsely certifies home health needs for Medicare beneficiaries.		1996	8/1/2016	7,512
Penalty for failure to report any final adverse action taken against a health care provider, supplier, or practitioner.	42 U.S.C. 1320a-7e(b)(6)(A)	1997	8/1/2016	36,794
Penalty for the misuse of words, symbols, or emblems in communications in a manner in which a person could falsely construe that such item is approved, endorsed, or authorized by HHS.	42 U.S.C. 1320b-10(b)(1)	1988	8/1/2016	9,893
Penalty for the misuse of words, symbols, or emblems in a broadcast or telecast in a manner in which a person could falsely construe that such item is approved, endorsed, or authorized by HHS.	42 U.S.C. 1320b-10(b)(2)	1988	8/1/2016	49,467
Penalty for certification of a false statement in assessment of functional capacity of a Skilled Nursing Facility resident assessment.	42 U.S.C. 1395i-3(b)(3)(B)(ii)(1)	1987	8/1/2016	2,063
Penalty for causing another to certify or make a false statement in assessment of functional capacity of a Skilled Nursing Facility resident assessment.	42 U.S.C. 1395i-3(b)(3)(B)(ii)(2)	1987	8/1/2016	10,314
Penalty for any individual who notifies or causes to be notified a Skilled Nursing Facility of the time or date on which a survey is to be conducted.	42 U.S.C. 1395i-3(g)(2)(A)	1987	8/1/2016	4,126
Penalty for a Medicare Advantage organization that substantially fails to provide medically necessary, required items and services.	42 U.S.C. 1395w-27(g)(2)(A)	1996	8/1/2016	37,561



# CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for a Medicare Advantage organization that charges excessive premiums.	42 U.S.C. 1395w-27(g)(2)(A)	1997	8/1/2016	36,794
Penalty for a Medicare Advantage organization that improperly expels or refuses to reenroll a beneficiary.		1997	8/1/2016	36,794
Penalty for a Medicare Advantage organization that engages in practice that would reasonably be expected to have the effect of denying or discouraging enrollment.		1997	8/1/2016	147,177
Penalty per individual who does not enroll as a result of a Medicare Advantage organization's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.		1997	8/1/2016	22,077
Penalty for a Medicare Advantage organization misrepresenting or falsifying information to Secretary.		1997	8/1/2016	147,177
Penalty for a Medicare Advantage organization misrepresenting or falsifying information to individual or other entity.		1997	8/1/2016	36,794
Penalty for Medicare Advantage organization interfering with provider's advice to enrollee and non-MCO affiliated providers that balance bill enrollees.		1997	8/1/2016	36,794
Penalty for a Medicare Advantage organization that employs or contracts with excluded individual or entity.		1997	8/1/2016	36,794
Penalty for a Medicare Advantage organization enrolling an individual in without prior written consent.		2010	8/1/2016	36,794
Penalty for a Medicare Advantage organization transferring an enrollee to another plan without consent or solely for the purpose of earning a commission.		2010	8/1/2016	36,794
Penalty for a Medicare Advantage organization failing to comply with marketing restrictions or applicable implementing regulations or guidance.		2010	8/1/2016	36,794
Penalty for a Medicare Advantage organization employing or contracting with an individual or entity who violates 1395w-27(g)(1)(A)-(J).		2010	8/1/2016	36,794
Penalty for a prescription drug card sponsor that falsifies or misrepresents marketing materials, overcharges program enrollees, or misuse transitional assistance funds.	42 U.S.C. 1395w-141(i)(3)	2003	8/1/2016	12,856
Penalty for improper billing by Hospitals, Critical Access Hospitals, or Skilled Nursing Facilities.	42 U.S.C. 1395cc(g)	1972	8/1/2016	5,000
Penalty for a hospital or responsible physician dumping patients needing emergency medical care, if the hospital has 100 beds or more.	42 U.S.C. 1395dd(d)(1)	1987	8/1/2016	103,139
Penalty for a hospital or responsible physician dumping patients needing emergency care, if the hospital has less than 100 beds.		1987	8/1/2016	51,570

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for a HMO or competitive plan is such plan substantially fails to provide medically necessary, required items or services	42 U.S.C. 1395mm(i)(6)(B)(i)	1987	8/1/2016	51,570
Penalty for HMOs/competitive medical plans that charge premiums in excess of permitted amounts		1987	8/1/2016	51,570
Penalty for a HMO or competitive medical plan that expels or refuses to reenroll an individual per prescribed conditions		1987	8/1/2016	51,570
Penalty for a HMO or competitive medical plan that implements practices to discourage enrollment of individuals needing services in future.		1987	8/1/2016	206,278
Penalty per individual not enrolled in a plan as a result of a HMO or competitive medical plan that implements practices to discourage enrollment of individuals needing services in the future.		1988	8/1/2016	29,680
Penalty for a HMO or competitive medical plan that misrepresents or falsifies information to the Secretary.		1987	8/1/2016	206,278
Penalty for a HMO or competitive medical plan that misrepresents or falsifies information to an individual or any other entity.		1987	8/1/2016	51,570
Penalty for failure by HMO or competitive medical plan to assure prompt payment of Medicare risk sharing contracts or incentive plan provisions.		1987	8/1/2016	51,570
Penalty for HMO that employs or contracts with excluded individual or entity.		1989	8/1/2016	47,340
Penalty for submitting or causing to be submitted claims in violation of the Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(3)	1994	8/1/2016	23,863
Penalty for circumventing Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(4)	1994	8/1/2016	159,089
Penalty for a material misrepresentation regarding Medigap compliance policies.	42 U.S.C. 1395ss(d)(1)	1988	8/1/2016	9,893
Penalty for selling Medigap policy under false pretense.	42 U.S.C. 1395ss(d)(2)	1988	8/1/2016	9,893
Penalty for an issuer that sells health insurance policy that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	1990	8/1/2016	44,539
Penalty for someone other than issuer that sells health insurance that duplicates benefits.		1990	8/1/2016	26,723
Penalty for using mail to sell a non-approved Medigap insurance policy.	42 U.S.C. 1395ss(d)(4)(A)	1988	8/1/2016	9,893
Penalty for a Medicaid MCO that substantially fails to provide medically necessary, required items or services.	42 U.S.C. 1396b(m)(5)(B)(i)	1988	8/1/2016	49,467

# CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for a Medicaid MCO that charges excessive premiums.	42 U.S.C. 1396b(m)(5)(B)(i)	1988	8/1/2016	49,467
Penalty for a Medicaid MCO that improperly expels or refuses to reenroll a beneficiary.		1988	8/1/2016	197,869
Penalty per individual who does not enroll as a result of a Medicaid MCO's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.		1988	8/1/2016	29,680
Penalty for a Medicaid MCO misrepresenting or falsifying information to the Secretary.		1988	8/1/2016	197,869
Penalty for a Medicaid MCO misrepresenting or falsifying information to an individual or another entity.		1988	8/1/2016	49,467
Penalty for a Medicaid MCO that fails to comply with contract requirements with respect to physician incentive plans.		1990	8/1/2016	44,539
Penalty for willfully and knowingly certifying a material and false statement in a Skilled Nursing Facility resident assessment.	42 U.S.C. 1396r(b)(3)(B)(ii)(I)	1987	8/1/2016	2,063
Penalty for willfully and knowingly causing another individual to certify a material and false statement in a Skilled Nursing Facility resident assessment.	42 U.S.C. 1396r(b)(3)(B)(ii)(II)	1987	8/1/2016	10,314
Penalty for notifying or causing to be notified a Skilled Nursing Facility of the time or date on which a survey is to be conducted.	42 U.S.C. 1396r(g)(2)(A)(i)	1987	8/1/2016	4,126
Penalty for the knowing provision of false information or refusing to provide information about charges or prices of a covered outpatient drug.	42 U.S.C. 1396r-8(b)(3)(B)	1990	8/1/2016	178,156
Penalty per day for failure to timely provide information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(i)	1990	8/1/2016	17,816
Penalty for knowing provision of false information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(ii)	1990	8/1/2016	178,156
Penalty for notifying home and community-based providers or settings of survey.	42 U.S.C. 1396t(i)(3)(A)	1990	8/1/2016	3,563
Penalty for failing to report a medical malpractice claim to National Practitioner Data Bank.	42 U.S.C. 11131(c)	1986	8/1/2016	21,563
Penalty for breaching confidentiality of information reported to National Practitioner Data Bank.	42 U.S.C. 11137(b)(2)	1986	8/1/2016	21,563

## Food and Drug Administration

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for violations related to drug samples resulting in a conviction of any representative of manufacturer or distributor in any 10-year period.	21 U.S.C. 333(b)(2)(A)	1988	8/1/2016	\$ 98,935

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for violation related to drug samples resulting in a conviction of any representative of manufacturer or distributor after the second conviction in any 10-yr period.	21 U.S.C. 333(b)(2)(B)	1988	8/1/2016	1,978,690
Penalty for failure to make a report required by 21 U.S.C. 353(d)(3)(E) relating to drug samples.	21 U.S.C 333(b)(3)	1988	8/1/2016	197,869
Penalty for any person who violates a requirement related to devices for each such violation.	21 U.S.C 333(f)(1)(A)	1990	8/1/2016	26,723
Penalty for aggregate of all violations related to devices in a single proceeding.		1990	8/1/2016	1,781,560
Penalty for any individual who introduces or delivers for introduction into interstate commerce food that is adulterated per 21 U.S.C. 342(a)(2)(B) or any individual who does not comply with a recall order under 21 U.S.C. 350l.	21 U.S.C 333(f)(2)(A)	1996	8/1/2016	75,123
Penalty in the case of any other person other than an individual) for such introduction or delivery of adulterated food.		1996	8/1/2016	375,613
Penalty for aggregate of all such violations related to adulterated food adjudicated in a single proceeding.		1996	8/1/2016	751,225
Penalty for all violations adjudicated in a single proceeding for any person who fails to submit certification required by 42 U.S.C. 282(j)(5)(B) or knowingly submitting a false certification.	21 U.S.C 333(f)(3)(A)	2007	8/1/2016	11,383
Penalty for all violations adjudicated in a single proceeding for any person who violates 21 U.S.C. 331(j)(1) by failing to submit the certification required by 42 U.S.C. 282(j)(5)(B) or knowingly submitting a false certification; by failing to submit clinical trial information under 42 U.S.C 282(j); or by submitting clinical trial information under 42 U.S.C. 282(j) that is false or misleading in any particular under 42 U.S.C. 282(j)(5)(D).	21 U.S.C 333(f)(3)(B)	2007	8/1/2016	11,383
Penalty for any responsible person that violates a requirement of 21 U.S.C. 355(o) (post-marketing studies, clinical trials, labeling), 21 U.S.C. 355(p) (risk evaluation and mitigation (REMS)), or 21 U.S.C. 355-1 (REMS).	21 U.S.C 333(f)(4)(A)(i)	2007	8/1/2016	284,583
Penalty for aggregate of all such above violations in a single proceeding.		2007	8/1/2016	1,138,330
Penalty for REMS violation that continues after written notice to the responsible person for the first 30-day period (or any portion thereof) the responsible person continues to be in violation.	21 U.S.C 333(f)(4)(A)(ii)	2007	8/1/2016	284,583
Penalty for REMS violation that continues after written notice to responsible person doubles for every 30-day period thereafter the violation continues, but may not exceed penalty amount for any 30-day period.		2007	8/1/2016	1,138,330
Penalty for aggregate of all such above violations adjudicated in a single proceeding.		2007	8/1/2016	11,383,300
Penalty for any person who violates a requirement which relates to tobacco products for each such violation	21 U.S.C 333(f)(9)(A)	2009	8/1/2016	16,503
Penalty for aggregate of all such violations of tobacco product requirement adjudicated in a single proceeding.		2009	8/1/2016	1,100,200
Penalty per violation related to violations of tobacco requirements.	21 U.S.C 333(f)(9)(B)(i)(I)	2009	8/1/2016	275,050
Penalty for aggregate of all such violations of tobacco product requirements adjudicated in a single proceeding.		2009	8/1/2016	1,100,200
Penalty in the case of a violation of tobacco product requirements that continues after written notice to such person, for the first 30-day period (or any portion thereof) the person continues to be in violation.	21 U.S.C 333(f)(9)(B)(i)(II)	2009	8/1/2016	275,050

# CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for violation of tobacco product requirements that continues after written notice to such person shall double for every 30-day period thereafter the violation continues, but may not exceed penalty amount for any 30-day period.	21 U.S.C 333(f)(9)(B)(i)(II)	2009	8/1/2016	1,100,200
Penalty for aggregate of all such violations related to tobacco product requirements adjudicated in a single proceeding.		2009	8/1/2016	11,002,000
Penalty for any person who either does not conduct post-market surveillance and studies to determine impact of a modified risk tobacco product for which the HHS Secretary has provided them an order to sell, or who does not submit a protocol to the HHS Secretary after being notified of a requirement to conduct post-market surveillance of such tobacco products.	21 U.S.C 333(f)(9)(B)(ii)(I)	2009	8/1/2016	275,050
Penalty for aggregate of for all such above violations adjudicated in a single proceeding.		2009	8/1/2016	1,100,200
Penalty for violation of modified risk tobacco product post-market surveillance that continues after written notice to such person for the first 30-day period (or any portion thereof) that the person continues to be in violation.	21 U.S.C 333(f)(9)(B)(ii)(II)	2009	8/1/2016	275,050
Penalty for post-notice violation of modified risk tobacco product post-market surveillance shall double for every 30-day period thereafter that the tobacco product requirement violation continues for any 30-day period, but may not exceed penalty amount for any 30-day period.		2009	8/1/2016	1,100,200
Penalty for aggregate above tobacco product requirement violations adjudicated in a single proceeding.		2009	8/1/2016	11,002,000
Penalty for any person who disseminates or causes another party to disseminate a direct-to-consumer advertisement that is false or misleading for the first such violation in any 3-year period.	21 U.S.C 333(g)(1)	2007	8/1/2016	284,583
Penalty for each subsequent above violation in any 3-year period.		2007	8/1/2016	569,165
Penalty to be applied for violations of restrictions on the sale or distribution of tobacco products promulgated under 21 U.S.C. 387f(d) (e.g., violations of regulations in 21 CFR Part 1140) with respect to a retailer with an approved training program in the case of a second regulation violation within a 12-month period.	21 U.S.C 333 note	2009	8/1/2016	275
Penalty in the case of a third tobacco product regulation violation within a 24-month period.		2009	8/1/2016	550
Penalty in the case of a fourth tobacco product regulation violation within a 24-month period.		2009	8/1/2016	2,200
Penalty in the case of a fifth tobacco product regulation violation within a 36-month period.		2009	8/1/2016	5,501
Penalty in the case of a sixth or subsequent tobacco product regulation violation within a 48-month period as determined on a case-by-case basis.	21 U.S.C 333 note	2009	8/1/2016	11,002
Penalty to be applied for violations of restrictions on the sale or distribution of tobacco products promulgated under 21 U.S.C. 387f(d) (e.g., violations of regulations in 21 CFR Part 1140) with respect to a retailer that does not have an approved training program in the case of the first regulation violation.		2009	8/1/2016	275
Penalty in the case of a second tobacco product regulation violation within a 12-month period.		2009	8/1/2016	550

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty in the case of a third tobacco product regulation violation within a 24-month period.	21 U.S.C 333 note	2009	8/1/2016	1,100
Penalty in the case of a fourth tobacco product regulation violation within a 24-month period.		2009	8/1/2016	2,200
Penalty in the case of a fifth tobacco product regulation violation within a 36-month period.		2009	8/1/2016	5,501
Penalty in the case of a sixth or subsequent tobacco product regulation violation within a 48-month period as determined on a case-by-case basis.		2009	8/1/2016	11,002
Penalty for each violation for any individual who made a false statement or misrepresentation of a material fact, bribed, destroyed, altered, removed, or secreted, or procured the destruction, alteration, removal, or secretion of, any material document, failed to disclose a material fact, obstructed an investigation, employed a consultant who was debarred, debarred individual provided consultant services.	21 U.S.C 335b(a)	1992	8/1/2016	419,320
Penalty in the case of any other person (other than an individual) per above violation.		1992	8/1/2016	1,677,280
Penalty for any person who violates any such requirements for electronic products, with each unlawful act or omission constituting a separate violation.	21 U.S.C 360pp(b)(1)	1968	8/1/2016	2,750
Penalty imposed for any related series of violations of requirements relating to electronic products.		1968	8/1/2016	937,500
Penalty per day for violation of order of recall of biological product presenting imminent or substantial hazard.	42 U.S.C. 262(d)	1986	8/1/2016	215,628
Penalty for failure to obtain a mammography certificate as required.	42 U.S.C.263b(h)(3)	1992	8/1/2016	16,773
Penalty per occurrence for any vaccine manufacturer that intentionally destroys, alters, falsifies, or conceals any record or report required.	42 U.S.C. 300aa-28(b)(1)	1986	8/1/2016	215,628

## Centers for Medicare &amp; Medicaid Services

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for a clinical laboratory's failure to meet participation and certification requirements and poses immediate jeopardy.	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)		8/1/2016	
Minimum		1988	8/1/2016	\$ 6,035
Maximum		1988	8/1/2016	19,787
Penalty for a clinical laboratory's failure to meet participation and certification requirements and the failure does not pose immediate jeopardy.			8/1/2016	
Minimum		1988	8/1/2016	99
Maximum		1988	8/1/2016	5,936
Failure to provide the Summary of Benefits and Coverage (SBC)	42 U.S.C. 300gg-15(f)	2010	8/1/2016	1,087
Penalty for violations of regulations related to the medical loss ratio reporting and rebating.	42 U.S.C. 300gg-18	2010	8/1/2016	109
Penalty for manufacturer or group purchasing organization failing to report information required under 42 USC 1320a-7h(a), relating to physician ownership or investment interests	42 U.S.C. 1320a-7h(b)(1)		8/1/2016	
Minimum		2010	8/1/2016	1,087
Maximum		2010	8/1/2016	10,874
Calendar Year Cap		2010	8/1/2016	163,117

# CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for manufacturer or group purchasing organization knowingly failing to report information required under 42 USC 1320a-7h(a) , relating to physician ownership or investment interests	42 U.S.C. 1320a-7h(b)(2)		8/1/2016	
Minimum		2010	8/1/2016	10,874
Maximum		2010	8/1/2016	108,745
Calendar Year Cap		2010	8/1/2016	1,087,450
Penalty for an administrator of a facility that fails to comply with notice requirements for the closure of a facility.	42 U.S.C. 1320a-7(h)(3)(A)	2010	8/1/2016	108,745
Minimum penalty for the first offense of an administrator who fails to provide notice of facility closure.		2010	8/1/2016	544
Minimum penalty for the second offense of an administrator who fails to provide notice of facility closure.		2010	8/1/2016	1,631
Minimum penalty for the third and subsequent offenses of an administrator who fails to provide notice of facility closure.		2010	8/1/2016	3,262
Penalty for an entity knowingly making a false statement or representation of material fact in the determination of the amount of benefits or payments related to old-age, survivors, and disability insurance benefits, special benefits for certain World War II veterans, or supplemental security income for the aged, blind, and disabled.	42 U.S.C. 1320a-8(a)(1)	1994	8/1/2016	7,954
Penalty for the violation of 42 USC 1320a-8a(1) if the violator is a person who receives a fee or other income for services performed in connection with determination of the benefit amount or the person is a physician or other health care provider who submits evidence in connection with such a determination.		2015	8/1/2016	7,500
Penalty for a representative payee (under 42 USC 405(j), 1007, or 1383(a)(2)) converting any part of a received payment from the benefit programs described in the previous civil monetary penalty to a use other than for the benefit of the beneficiary.	42 U.S.C. 1320a-8(a)(3)	2004	8/1/2016	6,229
Penalty for failure of covered individuals to report to the Secretary and 1 or more law enforcement officials any reasonable suspicion of a crime against a resident, or individual receiving care, from a long-term care facility.	42 U.S.C. 1320b-25(c)(1)(A)	2010	8/1/2016	217,490
Penalty for failure of covered individuals to report to the Secretary and 1 or more law enforcement officials any reasonable suspicion of a crime against a resident, or individual receiving care, from a long-term care facility if such failure exacerbates the harm to the victim of the crime or results in the harm to another individual.	42 U.S.C. 1320b-25(c)(2)(A)	2010	8/1/2016	326,235
Penalty for a long-term care facility that retaliates against any employee because of lawful acts done by the employee, or files a complaint or report with the State professional disciplinary agency against an employee or nurse for lawful acts done by the employee or nurse.	42 U.S.C. 1320b-25(d)(2)	2010	8/1/2016	217,490
Penalty for any person who knowingly and willfully fails to furnish a beneficiary with an itemized statement of items or services within 30 days of the beneficiary's request.	42 U.S.C. 1395b-7(b)(2)(B)	1997	8/1/2016	147
Penalty per day for a Skilled Nursing Facility that has a Category 2 violation of certification requirements.	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)		8/1/2016	
Minimum		1987	8/1/2016	103
Maximum		1987	8/1/2016	6,188

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty per instance of Category 2 noncompliance by a Skilled Nursing Facility.	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)		8/1/2016	
Minimum		1987	8/1/2016	2,063
Maximum		1987	8/1/2016	20,628
Penalty per day for a Skilled Nursing Facility that has a Category 3 violation of certification requirements.			8/1/2016	
Minimum		1987	8/1/2016	6,291
Maximum		1987	8/1/2016	20,628
Penalty per instance of Category 3 noncompliance by a Skilled Nursing Facility.			8/1/2016	
Minimum		1987	8/1/2016	2,063
Maximum		1987	8/1/2016	20,628
Penalty per day and per instance for a Skilled Nursing Facility that has Category 3 noncompliance with Immediate Jeopardy			8/1/2016	
Per Day (Minimum)		1987	8/1/2016	6,291
Per Day (Maximum)		1987	8/1/2016	20,628
Per Instance (Minimum)		1987	8/1/2016	2,063
Per Instance (Maximum)		1987	8/1/2016	20,628
Penalty per day of a Skilled Nursing Facility that fails to meet certification requirements. These amounts represent the upper range per day.			8/1/2016	
Minimum		1987	8/1/2016	6,291
Maximum		1987	8/1/2016	20,628
Penalty per day of a Skilled Nursing Facility that fails to meet certification requirements. These amounts represent the lower range per day.			8/1/2016	
Minimum		1987	8/1/2016	103
Maximum		1987	8/1/2016	6,188
Penalty per instance of a Skilled Nursing Facility that fails to meet certification requirements.			8/1/2016	
Minimum		1987	8/1/2016	2,063
Maximum		1987	8/1/2016	20,628
Penalty for knowingly, willfully, and repeatedly billing for a clinical diagnostic laboratory test other than on an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395l(h)(5)(D)	1996	8/1/2016	15,024
Penalty for knowingly and willfully presenting or causing to be presented a bill or request for payment for an intraocular lens inserted during or after cataract surgery for which the Medicare payment rate includes the cost of acquiring the class of lens involved.	42 U.S.C. 1395l(i)(6)	1988	8/1/2016	3,957
Penalty for knowingly and willfully failing to provide information about a referring physician when seeking payment on an unassigned basis.	42 U.S.C. 1395l(q)(2)(B)(i)	1989	8/1/2016	3,787
Penalty for any durable medical equipment supplier that knowingly and willfully charges for a covered service that is furnished on a rental basis after the rental payments may no longer be made. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(a)(11)(A)	1996	8/1/2016	15,024



# CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for any nonparticipating durable medical equipment supplier that knowingly and willfully fails to make a refund to Medicare beneficiaries for a covered service for which payment is precluded due to an unsolicited telephone contact from the supplier. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(a)(18)(B)	1996	8/1/2016	15,024
Penalty for any nonparticipating physician or supplier that knowingly and willfully charges a Medicare beneficiary more than the limiting charge for radiologist services. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(b)(5)(C)	1996	8/1/2016	15,024
Penalty for any supplier of prosthetic devices, orthotics, and prosthetics that knowing and willfully charges for a covered prosthetic device, orthotic, or prosthetic that is furnished on a rental basis after the rental payment may no longer be made. (Penalties are assessed in the same manner as 42 USC 1395m(a)(11)(A), that is in the same manner as 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(h)(3)	1996	8/1/2016	15,024
Penalty for any supplier of durable medical equipment including a supplier of prosthetic devices, prosthetics, orthotics, or supplies that knowingly and willfully distributes a certificate of medical necessity in violation of Section 1834(j)(2)(A)(i) of the Act or fails to provide the information required under Section 1834(j)(2)(A)(ii) of the Act.	42 U.S.C. 1395m(j)(2)(A)(iii)	1994	8/1/2016	1,591
Penalty for any supplier of durable medical equipment, including a supplier of prosthetic devices, prosthetics, orthotics, or supplies that knowingly and willfully fails to make refunds in a timely manner to Medicare beneficiaries for series billed other than on an assignment-related basis under certain conditions. (Penalties are assessed in the same manner as 42 USC 1395m(j)(4) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(j)(4)	1996	8/1/2016	15,024
Penalty for any person or entity who knowingly and willfully bills or collects for any outpatient therapy services or comprehensive outpatient rehabilitation services on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395m(k)(6) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(k)(6)	1996	8/1/2016	15,024
Penalty for any supplier of ambulance services who knowingly and willfully bills or collects for any services on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395u(b)(18)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(l)(6)	1996	8/1/2016	15,024
Penalty for any practitioner specified in Section 1842(b)(18)(C) of the Act or other person that knowingly and willfully bills or collects for any services by the practitioners on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(b)(18)(B)	1996	8/1/2016	15,024
Penalty for any physician who charges more than 125% for a non-participating referral. (Penalties are assessed in the same manner as 42 USC 1320a-7a(a)).	42 U.S.C. 1395u(j)(2)(B)	1996	8/1/2016	15,024

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for any physician who knowingly and willfully presents or causes to be presented a claim for bill for an assistant at a cataract surgery performed on or after March 1, 1987, for which payment may not be made because of section 1862(a)(15). (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(k)	1996	8/1/2016	15,024
Penalty for any nonparticipating physician who does not accept payment on an assignment-related basis and who knowingly and willfully fails to refund on a timely basis any amounts collected for services that are not reasonable or medically necessary or are of poor quality under 1842(l)(1)(A). (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(l)(3)	1996	8/1/2016	15,024
Penalty for any nonparticipating physician charging more than \$500 who does not accept payment for an elective surgical procedure on an assignment related basis and who knowingly and willfully fails to disclose the required information regarding charges and coinsurance amounts and fails to refund on a timely basis any amount collected for the procedure in excess of the charges recognized and approved by the Medicare program. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(m)(3)	1996	8/1/2016	15,024
Penalty for any physician who knowingly, willfully, and repeatedly bills one or more beneficiaries for purchased diagnostic tests any amount other than the payment amount specified by the Act. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(n)(3)	1996	8/1/2016	15,024
Penalty for any practitioner specified in Section 1842(b)(18)(C) of the Act or other person that knowingly and willfully bills or collects for any services pertaining to drugs or biologics by the practitioners on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395u(b)(18)(B) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(o)(3)(B)	1996	8/1/2016	15,024
Penalty for any physician or practitioner who knowingly and willfully fails promptly to provide the appropriate diagnosis codes upon CMS or Medicare administrative contractor request for payment or bill not submitted on an assignment-related basis.	42 U.S.C. 1395u(p)(3)(A)	1988	8/1/2016	3,957
Penalty for a pharmaceutical manufacturer's misrepresentation of average sales price of a drug, or biologic.	42 U.S.C. 1395w-3a(d)(4)(A)	2003	8/1/2016	12,856
Penalty for any nonparticipating physician, supplier, or other person that furnishes physician services not on an assignment-related basis who either knowingly and willfully bills or collects in excess of the statutorily-defined limiting charge or fails to make a timely refund or adjustment. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(1)(B)	1996	8/1/2016	15,024

# CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for any person that knowingly and willfully bills for statutorily defined State-plan approved physicians' services on any other basis than an assignment-related basis for a Medicare/Medicaid dual eligible beneficiary. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(3)(B)	1996	8/1/2016	15,024
Penalty for each termination determination the Secretary makes that is the result of actions by a Medicare Advantage organization or Part D sponsor that has adversely affected an individual covered under the organization's contract.	42 U.S.C. 1395w-27(g)(3)(A); 42 U.S.C. 1857(g)(3)	1997	8/1/2016	36,794
Penalty for each week beginning after the initiation of civil money penalty procedures by the Secretary because a Medicare Advantage organization or Part D sponsor has failed to carry out a contract, or has carried out a contract inconsistently with regulations.	42 U.S.C. 1395w-27(g)(3)(B); 42 U.S.C. 1857(g)(3)	1997	8/1/2016	14,718
Penalty for a Medicare Advantage organization's or Part D sponsor's early termination of its contract.	42 U.S.C. 1395w-27(g)(3)(D); 42 U.S.C. 1857(g)(3)	2000	8/1/2016	136,689
Penalty for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits not to enroll under a group health plan or large group health plan which would be a primary plan.	42 U.S.C. 1395y(b)(3)(C)	1990	8/1/2016	8,908
Penalty for any non-governmental employer that, before October 1, 1998, willfully or repeatedly failed to provide timely and accurate information requested relating to an employee's group health insurance coverage.	42 U.S.C. 1395y(b)(5)(C)(ii)	1998	8/1/2016	1,450
Penalty for any entity that knowingly, willfully, and repeatedly fails to complete a claim form relating to the availability of other health benefits in accordance with statute or provides inaccurate information relating to such on the claim form.	42 U.S.C. 1395y(b)(6)(B)	1994	8/1/2016	3,182
Penalty for any entity serving as insurer, third party administrator, or fiduciary for a group health plan that fails to provide information that identifies situations where the group health plan is or was a primary plan to Medicare to the HHS Secretary.	42 U.S.C. 1395y(b)(7)(B)(i)	2007	8/1/2016	1,138
Penalty for any non-group health plan that fails to identify claimants who are Medicare beneficiaries and provide information to the HHS Secretary to coordinate benefits and pursue any applicable recovery claim.	42 U.S.C. 1395y(b)(8)(E)	2007	8/1/2016	1,138
Penalty for any person that fails to report information required by HHS under Section 1877(f) concerning ownership, investment, and compensation arrangements.	42 U.S.C. 1395nn(g)(5)	1989	8/1/2016	18,936
Penalty for any durable medical equipment supplier, including a supplier of prosthetic devices, prosthetics, orthotics, or supplies, that knowingly and willfully fails to make refunds in a timely manner to Medicare beneficiaries under certain conditions. (42 USC 1395(m)(18) sanctions apply here in the same manner, which is under 1395u(j)(2) and 1320a-7a(a)).	42 U.S.C. 1395pp(h)	1996	8/1/2016	15,024
Penalty for any person that issues a Medicare supplemental policy that has not been approved by the State regulatory program or does not meet Federal standards after a statutorily defined effective date.	42 U.S.C. 1395ss(a)(2)	1987	8/1/2016	51,569
Penalty for someone other than issuer that sells or issues a Medicare supplemental policy to beneficiary without a disclosure statement.	42 U.S.C. 1395ss(d)(3)(A)(vi) (II)	1990	8/1/2016	26,723
Penalty for an issuer that sells or issues a Medicare supplemental policy without disclosure statement.		1990	8/1/2016	44,539

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for someone other than issuer that sells or issues a Medicare supplemental policy without acknowledgement form.	42 U.S.C. 1395ss(d)(3)(B)(iv)	1990	8/1/2016	26,723
Penalty for issuer that sells or issues a Medicare supplemental policy without an acknowledgement form		1990	8/1/2016	44,539
Penalty for any person that sells or issues Medicare supplemental policies after a given date that fail to conform to the NAIC or Federal standards established by statute.	42 U.S.C. 1395ss(p)(8)	1990	8/1/2016	26,723
Penalty for any person that sells or issues Medicare supplemental policies after a given date that fail to conform to the NAIC or Federal standards established by statute.		1990	8/1/2016	44,539
Penalty for any person that sells a Medicare supplemental policy and fails to make available for sale the core group of basic benefits when selling other Medicare supplemental policies with additional benefits or fails to provide the individual, before selling the policy, an outline of coverage describing benefits.	42 U.S.C. 1395ss(p)(9)(C)	1990	8/1/2016	26,723
Penalty for any person that sells a Medicare supplemental policy and fails to make available for sale the core group of basic benefits when selling other Medicare supplemental policies with additional benefits or fails to provide the individual, before selling the policy, an outline of coverage describing benefits.		1990	8/1/2016	44,539
Penalty for any person that fails to suspend the policy of a policyholder made eligible for medical assistance or automatically reinstates the policy of a policyholder who has lost eligibility for medical assistance, under certain circumstances.	42 U.S.C. 1395ss(q)(5)(C)	1990	8/1/2016	44,539
Penalty for any person that fails to provide refunds or credits as required by section 1882(r)(1)(B)	42 U.S.C. 1395ss(r)(6)(A)	1990	8/1/2016	44,539
Penalty for any issuer of a Medicare supplemental policy that does not waive listed time periods if they were already satisfied under a proceeding Medicare supplemental policy, or denies a policy, or conditions the issuances or effectiveness of the policy, or discriminates in the pricing of the policy base on health status or other specified criteria.	42 U.S.C. 1395ss(s)(4)	1990	8/1/2016	8,908
Penalty for any issuer of a Medicare supplemental policy that fails to fulfill listed responsibilities.	42 U.S.C. 1395ss(t)(2)	1990	8/1/2016	44,539
Penalty someone other than issuer who sells, issues, or renews a medigap Rx policy to an individual who is a Part D enrollee.	42 U.S.C. 1395ss(v)(4)(A)	2003	8/1/2016	19,284
Penalty for an issuer who sells, issues, or renews a Medigap Rx policy who is a Part D enrollee.		2003	8/1/2016	32,140
Penalty for any individual who notifies or causes to be notified a home health agency of the time or date on which a survey of such agency is to be conducted.	42 U.S.C. 1395bbb(c)(1)	1987	8/1/2016	4,126
Maximum daily penalty amount for each day a home health agency is not in compliance with statutory requirements.	42 U.S.C. 1395bbb(f)(2)(A)(i)	1988	8/1/2016	19,787
Penalty per day for home health agency's noncompliance (Upper Range).			8/1/2016	
Minimum		1988	8/1/2016	16,819
Maximum		1988	8/1/2016	19,787
Penalty for a home health agency's deficiency or deficiencies that cause immediate jeopardy and result in actual harm.		1988	8/1/2016	19,787
Penalty for a home health agency's deficiency or deficiencies that cause immediate jeopardy and result in potential for harm.		1988	8/1/2016	17,808
Penalty for an isolated incident of noncompliance in violation of established HHA policy.		1988	8/1/2016	16,819

# CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for a repeat and/or condition-level deficiency that does not constitute immediate jeopardy, but is directly related to poor quality patient care outcomes (Lower Range).	42 U.S.C. 1395bbb(f)(2)(A)(i)		8/1/2016	
Minimum		1988	8/1/2016	2,968
Maximum		1988	8/1/2016	16,819
Penalty for a repeat and/or condition-level deficiency that does not constitute immediate jeopardy and that is related predominately to structure or process-oriented conditions (Lower Range).			8/1/2016	
Minimum		1988	8/1/2016	989
Maximum		1988	8/1/2016	7,915
Penalty imposed for instance of noncompliance that may be assessed for one or more singular events of condition-level noncompliance that are identified and where the noncompliance was corrected during the onsite survey.			8/1/2016	
Minimum		1988	8/1/2016	1,979
Maximum		1988	8/1/2016	19,787
Penalty for each day of noncompliance (Maximum).		1988	8/1/2016	19,787
Penalty for each day of noncompliance (Maximum).		1988	8/1/2016	19,787
Penalty for PACE organization's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.	42 U.S.C. 1396b(m)(5)(B)		8/1/2016	
Minimum		1997	8/1/2016	22,077
Maximum		1997	8/1/2016	147,177
Penalty for a PACE organization that charges excessive premiums.		1997	8/1/2016	36,794
Penalty for a PACE organization misrepresenting or falsifying information to CMS, the State, or an individual or other entity.		1997	8/1/2016	147,177
Penalty for each determination the CMS makes that the PACE organization has failed to provide medically necessary items and services of the failure has adversely affected (or has the substantial likelihood of adversely affecting) a PACE participant.	42 U.S.C. 1396b(m)(5)(B)	1997	8/1/2016	36,794
Penalty for involuntarily disenrolling a participant.		1997	8/1/2016	36,794
Penalty for discriminating or discouraging enrollment or disenrollment of participants on the basis of an individual's health status or need for health care services		1997	8/1/2016	36,794
Penalty per day for a nursing facility's failure to meet a Category 2 Certification.	42 U.S.C. 1396r(h)(3)(C)(ii)(I)		8/1/2016	
Minimum		1987	8/1/2016	103
Maximum		1987	8/1/2016	6,188
Penalty per instance for a nursing facility's failure to meet Category 2 certification.			8/1/2016	
Minimum		1987	8/1/2016	2,063
Maximum		1987	8/1/2016	20,628
Penalty per day for a nursing facility's failure to meet Category 3 certification.			8/1/2016	
Minimum		1987	8/1/2016	6,291
Maximum		1987	8/1/2016	20,628

## CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty per instance for a nursing facility's failure to meet Category 3 certification.	42 U.S.C. 1396r(h)(3)(C)(ii)(I)		8/1/2016	
Minimum		1987	8/1/2016	2,063
Maximum		1987	8/1/2016	20,628
Penalty per instance for a nursing facility's failure to meet Category 3 certification, which results in immediate jeopardy.			8/1/2016	
Minimum		1987	8/1/2016	2,063
Maximum		1987	8/1/2016	20,628
Penalty per day for nursing facility's failure to meet certification (Upper Range).			8/1/2016	
Minimum		1987	8/1/2016	6,291
Maximum		1987	8/1/2016	20,628
Penalty per day for nursing facility's failure to meet certification (Lower Range).			8/1/2016	
Minimum		1987	8/1/2016	103
Maximum		1987	8/1/2016	6,188
Penalty per instance for nursing facility's failure to meet certification.			8/1/2016	
Minimum		1987	8/1/2016	2,063
Maximum		1987	8/1/2016	20,628
Grounds to prohibit approval of Nurse Aide Training Program - if assessed a penalty in 1819(h)(2)(B)(i) or 1919(h)(2)(A)(ii) of "not less than \$5,000" [Not CMP authority, but a specific CMP amount (CMP at this level) that is the triggering condition for disapproval]	42 U.S.C. 1396r(f)(2)(B)(iii)(I)(c)	1987	8/1/2016	10,314
Grounds to waive disapproval of nurse aide training program - reference to disapproval based on imposition of CMP "not less than \$5,000" [Not CMP authority but CMP imposition at this level determines eligibility to seek waiver of disapproval of nurse aide training program]	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	1987	8/1/2016	10,314
Penalty for each day of noncompliance for a home or community care provider that no longer meets the minimum requirements for home and community care.	42 U.S.C. 1396t(j)(2)(C)		8/1/2016	
Minimum		1990	8/1/2016	2
Maximum		1990	8/1/2016	17,816
Penalty for a Medicaid managed care organization that fails substantially to provide medically necessary items and services	42 U.S.C. 1396u-2(e)(2)(A)(i)	1997	8/1/2016	36,794
Penalty for Medicaid managed care organization that imposes premiums or charges on enrollees in excess of the premiums or charges permitted.		1997	8/1/2016	36,794
Penalty for a Medicaid managed care organization that misrepresents or falsifies information to another individual or entity.		1997	8/1/2016	36,794
Penalty for a Medicaid managed care organization that fails to comply with the applicable statutory requirements for such organizations.		1997	8/1/2016	36,794
Penalty for a Medicaid managed care organization that misrepresents or falsifies information to the HHS Secretary.	42 U.S.C. 1396u-2(e)(2)(A)(ii)	1997	8/1/2016	147,177
Penalty for Medicaid managed care organization that acts to discriminate among enrollees on the basis of their health status.		1997	8/1/2016	147,177
Penalty for each individual that does not enroll as a result of a Medicaid managed care organization that acts to discriminate among enrollees on the basis of their health status.	42 U.S.C. 1396u-2(e)(2)(A)(iv)	1997	8/1/2016	22,077

# CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level (\$ Amount)
Penalty for a provider not meeting one of the requirements relating to the protection of the health, safety, and welfare of individuals receiving community supported living arrangements services	42 U.S.C. 1396u(h)(2)	1990	8/1/2016	20,628
Penalty for disclosing information related to eligibility determinations for medical assistance programs	42 U.S.C. 1396w-2(c)(1)	2009	8/1/2016	11,002
Penalty for PACE organization's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.	42 U.S.C. 1903(m)(5)(B)		8/1/2016	
Minimum		1997	8/1/2016	22,077
Maximum		1997	8/1/2016	147,177
Penalty for a PACE organization that charges excessive premiums.		1997	8/1/2016	36,794
Penalty for a PACE organization misrepresenting or falsifying information to CMS, the State, or an individual or other entity.		1997	8/1/2016	147,177
Penalty for each determination the CMS makes that the PACE organization has failed to provide medically necessary items and services of the failure has adversely affected (or has the substantial likelihood of adversely affecting) a PACE participant.		1997	8/1/2016	36,794
Penalty for involuntarily disenrolling a participant.		1997	8/1/2016	36,794
Penalty for discriminating or discouraging enrollment or disenrollment of participants on the basis of an individual's health status or need for health care services		1997	8/1/2016	36,794
Failure to comply with requirements of <i>Public Health Services Act</i> ; Penalty for violations of rules or standards of behavior associated with issuer participation in the Federally-facilitated Exchange. (42 USC 300gg-22(b)(C)).	42 U.S.C. 18041(c)(2)	1996	8/1/2016	150
Penalty for providing false information on Exchange application.	42 U.S.C. 18081(h)(1)(A)(i)(II)	2010	8/1/2016	27,186
Penalty for knowingly or willfully providing false information on Exchange application.	42 U.S.C. 18081(h)(1)(B)	2010	8/1/2016	271,862
Penalty for knowingly or willfully disclosing protected information from Exchange.	42 U.S.C. 18081(h)(2)	2010	8/1/2016	27,186

## IMPROPER PAYMENTS INFORMATION ACT REPORT

### 1.0 Overview

HHS's FY 2016 Improper Payments Information Act Report includes a discussion of the following information, as required by the *Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA); Office of Management and Budget (OMB) Circular A-136; and Appendix C of OMB Circular A-123:

- Program Descriptions (Section 1.10)
- Risk Assessments (Section 2.0)
  - *Affordable Care Act* Risk Assessments (Section 2.10)
- Statistical Sampling Process (Section 3.0)
  - Error Rate Presentation (Section 3.10)
- Corrective Action Plans (CAPs) (Section 4.0)
  - Corrective Actions for High-Priority Programs (Section 4.10)
- Accountability in Reducing and Recovering Improper Payments (Section 5.0)
- Information Systems and Other Infrastructure (Section 6.0)
- Mitigation Efforts Related to Statutory or Regulatory Barriers (Section 7.0)
- FY 2016 Achievements (Section 8.0)
- Improper Payment Reduction Outlook FY 2015 through FY 2019 (Section 9.0)
  - Accompanying Improper Payment Reporting for OMB-Determined Risk-Susceptible Programs Notes (Section 9.10)
  - Accompanying Improper Payment Reporting for Superstorm Sandy Programs Notes (Section 9.20)
  - Accompanying Improper Payment Reporting for All Programs Notes (Section 9.30)
- Improper Payment Root Cause Categories (Section 10.0)
- Program-Specific Reporting Information (Section 11.0)
  - Medicare Fee-for-Service (FFS) (Parts A and B) (Section 11.10)
  - Medicare Advantage (Part C) (Section 11.20)
  - Medicare Prescription Drug Benefit (Part D) (Section 11.30)
  - Medicaid (Section 11.40)
  - Children's Health Insurance Program (CHIP) (Section 11.50)
  - Temporary Assistance for Needy Families (TANF) (Section 11.60)
  - Foster Care (Section 11.70)
  - Child Care and Development Fund (CCDF) (Section 11.80)
- Supplemental Measures and Targets for High-Priority Programs (Section 12.0)
- Superstorm Sandy Reporting Information (Section 13.0)
  - Head Start (Section 13.10)
  - Social Services Block Grant (SSBG) (Section 13.20)
  - Assistant Secretary for Preparedness and Response (ASPR) Research (Section 13.30)
  - Substance Abuse and Mental Health Services Administration (SAMHSA) (Section 13.40)
  - National Institutes of Health (NIH) Research (Section 13.50)
- Internal Control Over Payments (Section 14.0)
- Recovery Auditing Reporting (Section 15.0)
- Do Not Pay Initiative (Section 16.0)



## 1.10 Program Descriptions

The following is a brief description of the risk-susceptible programs discussed in this report. For the Superstorm Sandy risk-susceptible programs, the only programs included in the list below are those that are measuring and reporting improper payment estimates for FY 2016.

### ***OMB-Determined Risk-Susceptible Programs:***

1. **Medicare FFS** – A federal health insurance program for people age 65 or older, people younger than age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease.
2. **Medicare Part C** – A federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan.
3. **Medicare Part D** – A federal prescription drug benefit program for Medicare beneficiaries.
4. **Medicaid** – A joint federal/state program, administered by the states, that provides health insurance to certain low-income individuals.
5. **CHIP** – A joint federal/state program, administered by the states, that provides health insurance for qualifying children.
6. **TANF** – A joint federal/state program, administered by the states, that provides time-limited cash assistance as well as job preparation, work support, and other services to needy families with children to promote work, responsibility, and self-sufficiency.
7. **Foster Care** – A joint federal/state program, administered by the states, for children who need placement outside their homes in a foster family home or a child care facility.
8. **CCDF** – A joint federal/state program, administered by the states, that provides child care financial assistance to low-income working families.

### ***Superstorm Sandy Risk-Susceptible Programs:***

9. **Head Start** – A federal program that provides comprehensive developmental services for America's low-income children from birth to five years of age and their families.
10. **SSBG** – A joint federal/state program, administered by the states, which supports programs designed to reduce dependency and promote self-sufficiency; to protect children, adults, and people with disabilities from neglect, abuse, and exploitation; and to help individuals who are unable to take care of themselves to stay in their homes or to find the best institutional arrangement.
11. **ASPR Research** – A federal initiative to build a strong scientific research dataset and to support research that will aid in the response to, and recovery from, Superstorm Sandy.
12. **SAMHSA** – A joint federal/state initiative to provide continued and enhanced mental health and substance abuse treatment to affected parties.
13. **NIH Research** – A federal initiative to restore investment in biomedical research and infrastructure that was severely damaged or destroyed by Superstorm Sandy.

## 2.0 Risk Assessments

In addition to the programs deemed by OMB to be susceptible to significant improper payments and those required to be measured under the Superstorm Sandy *Disaster Relief Appropriations Act of 2013 (Disaster Relief Act)*, HHS also reviews other programs and payment streams to determine if they are susceptible to significant improper payments. Per Appendix C of OMB Circular A-123, Part I.A.9.Step1.b, the HHS IPERIA Risk Assessment Template contains nine factors that are reviewed:

1. Whether the program is new to the agency;

## IMPROPER PAYMENTS INFORMATION ACT REPORT

2. The complexity of the program, particularly determining correct payment amounts;
3. The volume of payments made annually;
4. Whether payments or payment eligibility decisions are made outside of the agency;
5. Recent major changes in program funding, authorities, practices, or procedures;
6. The level, experience, and quality of training for personnel responsible for making program eligibility determinations or certifying that payments are accurate;
7. Inherent risks of improper payments due to the nature of agency programs or operations;
8. Significant deficiencies in agency audit reports including, but not limited to, HHS Inspector General or Government Accountability Office (GAO) findings, or other relevant management findings; and
9. Results from prior improper payment work.

In addition to these risk factors, the HHS IPERIA Risk Assessment Template includes information on specific risks identified by the program that may lead to improper payments, as well as controls that may help mitigate those risks. By continuing to examine both the required risk factors and additional internal control information, the risk assessment tool provides a comprehensive review and analysis of selected programs' operations to determine if a payment risk exists and the nature and extent of the risks identified.

In FY 2016, HHS strengthened its risk assessment process and reporting activities with added policies and procedures. For example, the Department made minor refinements to the HHS IPERIA Risk Assessment Template to incorporate lessons learned from the previous year's risk assessments and incorporated best practices from the revised version of GAO's *Standards for Internal Control in the Federal Government*. Furthermore, the Department increased the number of programs conducting improper payment risk assessments from 9 programs in FY 2015 to 22 programs in FY 2016. For a complete list of programs HHS reviewed under its risk assessment approach, see *Figure 2.0*.

**Figure 2.0: FY 2016 Risk Assessments**

Operating or Staff Division	Program Name
Administration for Children and Families (ACF)	Head Start
	Low Income Home Energy Assistance Program
	TANF
Administration for Community Living (ACL)	Home and Community Based Supportive Services
	State Councils on Developmental Disabilities
Agency for Healthcare Research and Quality (AHRQ)	Health Costs, Quality, and Outcomes Program
	Medical Expenditure Panel Survey
Assistant Secretary for Preparedness and Response	Ebola Supplemental Patient Care Reimbursement Program
Centers for Disease Control and Prevention	Vaccine for Children
	National Center for Chronic Disease Prevention and Health Promotion
Food and Drug Administration (FDA)	Vendor Payments
Health Resources and Services Administration (HRSA)	Health Service Corps Loan Repayment and Scholarship Programs
	Maternal and Child Health Block Grant
Indian Health Service (IHS)	Grants Management
	Health Information Technology
National Institutes of Health	Student Loan Repayment Program
	Extramural Loan Repayment Programs
Office of the Assistant Secretary for Health (OASH)	Title X Family Planning Grant Program
	Teen Pregnancy Prevention Program

Operating or Staff Division	Program Name
Office of the National Coordinator for Health IT (ONC)	Regional Extension Center Program
Substance Abuse and Mental Health Services Administration	Addiction Technology Transfer Center Grants
	Residential Treatment for Pregnant and Postpartum Women

HHS determined that none of the programs that were risk assessed in FY 2016 were at-risk for significant improper payments.

In FY 2016, HHS also met IPERIA's requirement to assess the risk of charge cards and employee pay by leveraging existing Departmental activities and implementing a new risk assessment approach. For charge card payments, which includes both purchase and travel cards, HHS developed a new, qualitative risk assessment tool—similar to the risk assessment tool used to assess programs' susceptibility to significant improper payments. The new risk assessment tool uses data generated through existing evaluations such as those mandated by legislative and administrative processes in addition to the findings of continuous monitoring activities and OMB's nine required risk factors that are listed earlier in this section. One Staff Division (Program Support Center) and three Operating Divisions (FDA, NIH, and CDC), historically representing the majority of charge card expenditures, completed the charge card risk assessment process and were determined not to be at-risk for significant improper payments. For employee pay, the Department primarily utilized control testing performed during the OMB Circular A-123, Appendix A process, and findings from internal reviews and external audits, to perform the improper payment risk assessment. Based on these processes, the Department concluded that employee payments were not at-risk for significant improper payments.

## 2.10 Affordable Care Act Risk Assessments

HHS and the Department of the Treasury (Treasury) each have responsibilities for ensuring payment accuracy in Marketplace programs created under the *Affordable Care Act*. Performing program-specific comprehensive risk assessments provides reasonable assurance of whether improper payments could exceed statutory thresholds, and remains critical to evaluating and improving payment accuracy. HHS has conducted risk assessments to determine areas that might affect Advance Premium Tax Credit (APTC), Cost-Sharing Reduction (CSR), and other programs' payment accuracy; and Treasury has conducted a risk assessment to determine areas that might affect Premium Tax Credit (PTC) payment accuracy. The Department leveraged the same Federally Funded Research and Development Center to facilitate interagency coordination, information exchange, and risk analysis during the APTC and PTC program risk assessments.

Qualitative risk assessments of the Marketplace programs, administered by the Department, were conducted using the HHS IPERIA Risk Assessment Template, which provides guidance and criteria in assessing the risk factors listed in Appendix C of OMB Circular A-123, Part I.A.9.Step1.b (See *Section 2.0* for a list of those factors). The risk assessments also identified and evaluated potential improper payment risks. A complete list of Marketplace and related programs that HHS risk assessed is included below in *Figure 2.1*.

**Figure 2.1: FY 2016 Affordable Care Act Risk Assessments**

Operating Division	Program Name
Centers for Medicare & Medicaid Services	APTC
Centers for Medicare & Medicaid Services	CSR
Centers for Medicare & Medicaid Services	Basic Health Program (BHP)
Centers for Medicare & Medicaid Services	Consumer Operated and Oriented Plan
Centers for Medicare & Medicaid Services	Navigator Grants

Operating Division	Program Name
Centers for Medicare & Medicaid Services	Risk Adjustment
Centers for Medicare & Medicaid Services	Risk Corridors
Centers for Medicare & Medicaid Services	Transitional Reinsurance
Centers for Medicare & Medicaid Services	Small Business Health Options
Centers for Medicare & Medicaid Services	State Marketplace Establishment Grants
Centers for Medicare & Medicaid Services	Women's Preventative Services Exception

HHS concluded that the APTC and CSR programs are susceptible to significant improper payments (See *Figure 2.1.1*). HHS is deferring a final risk assessment conclusion for the BHP to allow the program to become more fully established. HHS determined that the remaining programs were not susceptible to significant improper payments. HHS will begin piloting improper payment measurement methodologies in FY 2017 for those programs deemed susceptible to significant improper payments, which will be used to develop annual estimates, report improper payments, and facilitate corrective actions. The BHP risk assessment conclusion and updates on the APTC and CSR improper payment measurement methodology development will be provided in the FY 2017 Agency Financial Report (AFR).

**Figure 2.1.1: FY 2016 Affordable Care Act Programs Susceptible to Significant Improper Payments**

	FY 2016 Risk Assessment Results		Year Rate and Amount will be reported
	Below Statutory Thresholds	Susceptible to Significant Improper Payments (IPs)	
APTC	No	Yes	To Be Determined*
CSR	No	Yes	To Be Determined*

\*Note: Currently, HHS is unable to specify the year the rate and amount will be reported due to the complexity and timing of the error rate measurement methodology development process, which involves conducting pilot testing, using those pilots to refine the methodology, and then undergoing the rule making process before implementing the methodology.

Treasury has completed the risk assessment for the PTC program. Treasury's risk assessment determination and a detailed discussion are reported in the appropriate sections of the FY 2016 Treasury AFR. In addition to the work on the improper payment risk assessments, both Departments have established internal controls to provide for effective program operations, reliable financial reporting, and compliance with laws and regulations.

### 3.0 Statistical Sampling Process

Each program's statistical sampling process is discussed in *Section 11.0: Program-Specific Reporting Information* or *Section 13.0: Superstorm Sandy Reporting Information*. Unless otherwise stated in either section, all programs that reported an error rate estimate complied with the requirement that all estimates be based on the equivalent of a statistically valid random sample of sufficient size to yield an estimate with a 90 percent confidence interval of plus or minus 2.5 percentage points of the total amount of all program payments around the estimate of the dollars of erroneous payments. In addition, seven of the eight programs that OMB determined susceptible to significant improper payments are reporting error estimates calculated by a statistical contractor.

#### 3.10 Error Rate Presentation

OMB Circular A-136 allows agencies to report net error rates in addition to the required gross error rates. Tables 1A and 1B in *Section 9.0: Improper Payment Reduction Outlook FY 2015 through FY 2019* present each high-risk or Superstorm Sandy program's gross and net error rates.

The *gross error rate* is the official program error rate; it is calculated by adding the sample's overpayments and underpayments and dividing by the total dollar value of the sample. The *net error rate* reflects the overall estimated monetary loss to the program; it is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample.

## 4.0 Corrective Action Plans (CAPs)

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Each program's CAP for reducing the estimated rate of improper payments can be found in *Section 11.0: Program-Specific Reporting Information* or *Section 13.0: Superstorm Sandy Reporting Information*. CAPs are used to set aggressive, realistic targets and outline a timetable to achieve scheduled targets. OMB approves all CAPs and reduction targets published in the AFR. The Department reviews CAPs annually to ensure plans focus on the root causes of the errors, thus making it more likely that targets are met. If targets are not met, HHS will develop new strategies, adjust staffing and other resources, and possibly revise targets.

Many successful corrective actions were listed as best practices in previous AFRs. Beginning with the FY 2016 improper payments reporting section, HHS will no longer include these best practices in its AFR. However, information on these best practices can be found at [www.hhs.gov/afr](http://www.hhs.gov/afr).

### 4.10 Corrective Actions for High-Priority Programs

Under Executive Order (EO) 13520 – “Reducing Improper Payments and Eliminating Waste in Federal Programs” - and its implementing guidance, OMB identifies programs that have more than \$750 million in annual estimated improper payments and that contribute substantially to the governmentwide improper payment estimate. These programs, known as high-priority programs, are required to perform certain activities, including: appointing Accountable Officials to oversee the agency's improper payment efforts; posting improper payment information to [www.PaymentAccuracy.gov](http://www.PaymentAccuracy.gov); and developing and reporting supplemental measures in addition to reporting the annual error rates.

HHS has five programs that OMB deemed high-priority programs: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, and CHIP. Accordingly, additional information on HHS's efforts can be found on [www.PaymentAccuracy.gov](http://www.PaymentAccuracy.gov). In addition, while the root causes of errors in the Department's programs can fluctuate from year to year, HHS remains focused on reducing the annual error rates for its high-priority programs and is taking many actions to prevent and reduce improper payments (see *Section 11.0* for more information on HHS's corrective actions, and *Section 12.0* for information on HHS's supplemental measures).

## 5.0 Accountability in Reducing and Recovering Improper Payments

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Strengthening program integrity throughout the organization is a top Departmental priority, extending to HHS senior executives and program officials at each of our agencies and programs. As evidence of this focus, beginning with senior leadership and cascading down, performance plans contain strategic goals that are related to strengthening program integrity, protecting taxpayer resources, and reducing improper payments. Senior executives and program officials are evaluated as part of their semi-annual and annual performance evaluations on their progress toward achieving these goals.

## 6.0 Information Systems and Other Infrastructure

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*Section 11.0: Program-Specific Reporting Information* details each program's information systems and other infrastructure.

## 7.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

*Section 11.0: Program-Specific Reporting Information* reports each program's statutory or regulatory barriers, if any, to reducing improper payments.

## 8.0 FY 2016 Achievements

In FY 2016, HHS strengthened its efforts to reduce and recover improper payments in its programs. While a few of these efforts are highlighted below, more detailed information on the programs' performance and corrective actions can be found in *Section 11.0: Program-Specific Reporting Information*.

### **Head Start**

As of FY 2013, Head Start no longer reports annual improper payment estimates due to the strong internal controls, monitoring systems, and low reported error rates from FY 2009 through FY 2012. In lieu of an annual error rate measurement, HHS provides oversight through Head Start's existing internal controls and monitoring systems, and annually reports to OMB on its internal controls. Overall, FY 2016 monitoring results indicate the number of grantees with erroneous payments related to eligibility remained consistently low, indicating that the Department's control and monitoring systems are working as intended.

### **Centers for Medicare & Medicaid Services (CMS) Program Integrity Board**

As part of HHS's efforts to reduce improper payments, CMS established an agency-wide Program Integrity (PI) Board to identify and prioritize improper, wasteful, abusive, and potentially fraudulent payment vulnerabilities in its programs. The PI Board is comprised of CMS executive leaders, all of whom share the mutual objective to identify and prevent improper and fraudulent payments. After identifying high-priority vulnerabilities, the PI Board directs corrective actions and tracks issues to resolution. Specifically, the PI Board established an Improper Payment Action Plan workgroup to periodically collect data from improper payment reports and formulate action plans for review by the PI Board. In FY 2016, the workgroup focused on vulnerabilities identified in the Medicare FFS, Medicare Parts C and D, and Medicaid and CHIP improper payment measurements. The PI Board also established smaller working groups—referred to as Integrated Project Teams (IPTs)—to focus on specific projects to address the identified vulnerabilities. For example, in FY 2015, the PI Board approved the Therapy Services IPT, Home Health IPT, and Medicare FFS Integrity Continuum IPT. In FY 2016, the PI Board approved the Marketplace IPT and Documentation Improvement IPT. Each IPT works independently under the directive of the PI Board and provides regular updates. Major initiatives include: launching the Pre-Claim Review Demonstration for Home Health Services in August 2016; releasing Skilled Nursing Facility (SNF) provider utilization and payment data in March 2016 that brought national attention to potential billing irregularities for therapy services; and launching the Provider Billing Review Evaluation in one Medicare Administrative Contractor (MAC) jurisdiction to help Medicare Part B providers analyze their coding and billing practices for specific procedures and services.

### **Affordable Care Act Provider Enrollment Moratorium**

Section 6401 of the *Affordable Care Act* added Section 1866(j)(7) to the *Social Security Act* that provides HHS the authority to impose a temporary moratorium on the enrollment of new providers and suppliers as a tool to prevent or combat fraud, waste, or abuse in Medicare, Medicaid, or CHIP. Establishing a moratorium in certain geographic areas provides HHS the opportunity to analyze and monitor the existing provider and supplier base, and to focus on additional fraud prevention and detection tools in the areas. On July 30, 2013, HHS launched the first temporary (6-month) enrollment moratorium pursuant to this authority for Miami-area and Chicago-area home health agencies (HHAs) and ground ambulance suppliers (emergency and non-emergency) in the Houston-area for Medicare, Medicaid, and CHIP. On January 30, 2014, HHS extended the original moratoria for these locations by 6 months and expanded the temporary enrollment moratoria to include HHAs in the Fort Lauderdale,

Detroit, Dallas, and Houston areas. HHS also expanded the moratoria for ground ambulance suppliers into the Philadelphia area and surrounding New Jersey counties. Since the initial expansion, moratoria for all areas were continued until July 2016.

Most recently, on July 29, 2016, HHS announced:

- The moratoria were expanded state-wide for HHAs in Florida, Illinois, Michigan, and Texas and for new Medicare Part B, Medicaid, and CHIP non-emergency ambulance suppliers in New Jersey, Pennsylvania, and Texas;
- HHS concurrently lifted the temporary moratoria on all Medicare Part B, Medicaid, and CHIP emergency ground ambulance suppliers; and
- HHS launched the Provider Enrollment Moratoria Access Waiver Demonstration, which grants waivers to the state-wide enrollment moratoria on a case-by-case basis in response to access to care issues in certain geographic areas and requires heightened initial review and ongoing oversight of new providers and suppliers.

The focus of these efforts is to prevent and deter fraud, waste, and abuse in high-risk services and areas across the country through the use of heightened screening for new providers and suppliers in the moratoria areas while ensuring beneficiary access to care.

#### ***Fraud Prevention System***

HHS launched the Fraud Prevention System (FPS) on June 30, 2011, as required by the *Small Business Jobs Act of 2010*. The FPS analyzes all Medicare FFS claims using risk-based algorithms developed by HHS and its contractors. HHS uses the FPS to target investigative resources, generating alerts for suspect claims or providers and suppliers in priority order, to investigate the most egregious, suspect, or aberrant activity. HHS and its program integrity contractors use the FPS information to prevent and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement.

During FY 2015, HHS took administrative action against 943 providers and suppliers, resulting in an estimated \$604.75 million in identified savings. These savings led to an \$11 to \$1 return on investment for FY 2015. Simultaneously, the FPS also generated leads for 492 new investigations and augmented information for 226 ongoing investigations. HHS is developing the next generation of predictive analytics with a new FPS system design that further improves its usability and efficiency. Through the award of the FPS 2.0 contract on April 1, 2016, HHS, in collaboration with its contractor, will modernize the FPS system to improve model performance measurement, optimize model development time to production, and aggressively expand program integrity capabilities.

#### ***National Benefit Integrity Medicare Drug Integrity Contractor***

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) performs data analysis to fight fraud, waste, and abuse in Medicare Part C and D. The NBI MEDIC identifies improper payments through data analysis and notifies plan sponsors to recover the corresponding overpayments. As a result of the NBI MEDIC's data analysis projects, HHS recovered \$78.53 million in FY 2016 from Part D sponsors. In addition, HHS utilizes the NBI MEDIC's data analysis to select Part D plan sponsors and drugs for review through self-audits conducted by Part D plan sponsors. HHS recovered \$6.25 million as a result of Part D plan sponsor self-audits in FY 2016. Lastly, the NBI MEDIC also refers some information to law enforcement organizations. According to notifications received from law enforcement for the first half of FY 2016, NBI MEDIC referrals to law enforcement resulted in recoveries of \$3.12 million for Part C and \$71.42 million for Part D. The majority of these savings were from sentences ordering restitution.



**Medicaid Integrity Program**

Under the authority of Section 1936 of the *Social Security Act*, as amended by the *Deficit Reduction Act of 2005* (DRA), HHS's Medicaid Integrity Program has two broad responsibilities:

- To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.
- To provide effective support and assistance to states in their efforts to combat Medicaid provider fraud, waste, and abuse.

Increased Medicaid recoveries, since the enactment of the DRA, demonstrate the increased focus on Medicaid integrity. For example, the Medicaid Integrity Program has provided the assistance of federal staff specializing in program integrity and contractor support to bolster state activities. Based on states' quarterly reports to HHS, this assistance contributed to \$784.50 million in total collections in FY 2016. The Medicaid Integrity Program works in coordination with the Medicaid program integrity activities funded by the Health Care Fraud and Abuse Control program. The DRA also required HHS to establish a Comprehensive Medicaid Integrity Plan to guide the Medicaid Integrity Program's development and operations. HHS's most recent Comprehensive Medicaid Integrity Plan for FYs 2014 to 2018 is available at [www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf). During FY 2016, HHS significantly expanded its efforts to assist states with meeting Medicaid screening and enrollment requirements through enhanced sharing of Medicare enrollment and screening data with states, providing a new data compare service to help states identify providers for which the state is able to rely on Medicare's screening, and providing technical assistance to states through site visits and publishing guidance in the Medicaid Provider Enrollment Compendium.

**Public Assistance Reporting Information System**

The Public Assistance Reporting Information System (PARIS) is a federal/state partnership with all 50 states, the District of Columbia, and Puerto Rico that provides state public assistance agencies detailed information and data to detect and deter improper payments in TANF, Medicaid, Workers' Compensation, Child Care, and the Supplemental Nutrition Assistance Program.

HHS, the Department of Veterans Affairs (VA), and the Department of Defense (DOD) have partnered to advance the PARIS project at no cost to states. The DOD's Defense Manpower Data Center provides computer resources to produce a match file, using social security numbers submitted by the states, VA, and DOD as the key match indicator. States verify the matched individual's eligibility and take any necessary action. HHS contributes to this effort by executing Computer Matching Agreements and coordinating the quarterly matches. Since its establishment, PARIS has strengthened program administration among its programs and state public assistance agencies. For instance, New York State closed 10,337 cases for cost avoidance of \$59.51 million during their most recent full state fiscal year (April 2015 to March 2016). More information on PARIS can be found at [www.acf.hhs.gov/paris](http://www.acf.hhs.gov/paris).

**9.0 Improper Payment Reduction Outlook FY 2015 through FY 2019**

The following tables (Table 1A, Table 1B, and Table 1C) display HHS's improper payment results for the current year (CY) FY 2016, the prior year (PY) FY 2015, and targets for FYs 2017 through 2019. The tables include the following information by year and program, as applicable: FY outlays, the error rate or future reduction target (IP%), and dollars paid or projected to be paid improperly (IP\$). In addition, for the CY, HHS includes: the amount of overpayments (CY Overpayments), the amount of underpayments (CY Underpayments), and the net error rate (CY Net IP%) and the corresponding overpayments (CY net IP\$), when available.

Table 1A includes improper payment information for HHS's OMB-determined risk-susceptible programs. Table 1B includes the FY 2016 improper payment results for the programs that received *Disaster Relief Act* funding and does



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not include current year estimates or out-year reduction targets for programs where all of the funds have been expended. Table 1C presents the Department's aggregate improper payment information.

**Table 1A**  
**Improper Payment Reporting for OMB-Determined Risk-Susceptible Programs**  
 FY 2015 – FY 2019 (in Millions)

Program or Activity	PY Outlays \$	PY IP %	PY IP \$	CY Outlays \$	CY IP %	CY IP \$	CY Over payment \$	CY Under payment \$	CY Net IP %	CY Net IP \$	CY+1 Est. Outlays \$	CY+1 IP %	CY+1 IP \$	CY+2 Est. Outlays \$	CY+2 IP %	CY+2 IP \$	CY+3 Est. Outlays \$	CY+3 IP %	CY+3 IP \$
Medicare FFS	358,348.60 Note (a)	12.09	43,325.61	373,650.45 Note (b)	11.00 Note (1)	41,084.65	39,844.92	1,239.72	10.33	38,605.20	403,555.00 Note (c)	10.40	41,969.72	426,865.00 Note (c)	9.40	40,125.31	450,505.00 Note (c)	9.30	41,896.97
Medicare Part C	148,593.71 Note (d)	9.50	14,117.00	161,944.04 Note (e)	9.99	16,182.66	11,484.39	4,698.27	4.19	6,786.12	201,283.00 Note (f)	9.50	19,121.89	200,296.00 Note (f)	9.10 Note (2)	18,226.94	235,803.00 Note (f)	9.10 Note (2)	21,458.07
Medicare Part D	62,003.91 Note (g)	3.60	2,234.25	70,235.94 Note (h)	3.41	2,393.94	1,660.84	733.09	1.32	927.75	98,322.00 Note (i)	3.30 Note (3)	3,244.63	97,366.00 Note (i)	3.20 Note (2)	3,115.71	113,152.00 Note (i)	3.20 Note (2)	3,620.86
Medicaid	297,672.02 Note (j)	9.78	29,124.61	345,973.72 Note (k)	10.48 Note (4)	36,253.25	35,750.72	502.53	10.19	35,248.19	364,710.61 Note (k)	9.57	34,902.81	371,939.82 Note (k)	6.68	24,845.58	396,104.79 Note (k)	5.51	21,825.37
CHIP	9,293.91 Note (l)	6.80	632.11	9,233.06 Note (m)	7.99 Note (5)	737.59	732.07	5.52	7.87	726.55	15,007.44 Note (m)	7.38	1,107.55	16,015.86 Note (m)	7.06	1,130.72	12,414.94 Note (m)	6.24	774.69
TANF	16,215.32 Note (n)	N/A	N/A	15,496.33 Note (o)	N/A Note (6)	N/A	N/A	N/A	N/A	N/A	17,042.12 Note (o)	N/A	N/A	16,528.39 Note (o)	N/A	N/A	16,593.63 Note (o)	N/A	N/A
Foster Care	841.01 Note (p)	3.65	30.68	692.00 Note (q)	6.89	47.68	46.50	1.18	6.55	45.32	771.00 Note (q)	6.60	50.89	837.00 Note (q)	6.30	52.73	897.00 Note (q)	6.00	53.82
Child Care	5,420.32 Note (r)	5.74	311.13	5,547.09 Note (s)	4.34 Note (7)	240.74	225.21	15.53	3.78	209.68	5,919.10 Note (s)	8.00 Note (7)	473.53	5,691.71 Note (s)	8.00 Note (7)	455.34	5,687.48 Note (s)	7.50 Note (7)	426.56
SUB-TOTAL Note (t)	882,173.48	10.18	89,775.39	967,276.30	10.02	96,940.51	89,744.65	7,195.84	8.53	82,548.81	1,089,568.15	9.26	100,871.02	1,119,011.39	7.86	87,952.33	1,214,564.21	7.41	90,056.34

Note: The Current Year (CY) CY+1, CY+2 and CY+3 estimated dollars paid improperly (IP\$) is calculated based on the target error rate and estimated outlays for each year, respectively. However, it is important to note that the measurement periods for each program vary. Therefore, the future outlay estimates presented may not be the actual amounts against which the error rates will be applied to compute the dollars paid improperly in future years.

## 9.10 Accompanying Improper Payment Reporting for OMB-Determined Risk-Susceptible Programs Notes

- a) Medicare FFS PY outlays are from the FY 2015 Medicare FFS Improper Payments Report (based on claims from July 2013 – June 2014).
  - b) Medicare FFS CY outlays are from the FY 2016 Medicare FFS Improper Payments Report (based on claims from July 2014 – June 2015).
  - c) Medicare FFS CY+1, CY+2, CY+3 outlays are based on the FY 2017 Midsession Review (Medicare Benefit Outlays current law (CL)).
  - d) Medicare Part C PY outlays reflect 2013 Part C payments, as reported in the FY 2015 Medicare Part C Payment Error Final Report.
  - e) Medicare Part C CY outlays reflect 2014 Part C payments, as reported in the FY 2016 Medicare Part C Payment Error Final Report.
  - f) Medicare Part C CY+1, CY+2, CY+3 outlays are based on the FY 2017 Midsession Review (Medicare Benefit Outlays (CL)).
  - g) Medicare Part D PY outlays reflect 2013 Part D payments, as reported in the FY 2015 Medicare Part D Payment Error Final Report.
  - h) Medicare Part D CY outlays reflect 2014 Part D payments, as reported in the FY 2016 Medicare Part D Payment Error Final Report.
  - i) Medicare Part D CY+1, CY+2, CY+3 outlays are based on the FY 2017 Midsession Review (Medicare Benefit Outlays (CL)).
  - j) Medicaid PY outlays (based on FY 2014 expenditures) are based on the FY 2016 Midsession Review and exclude CDC Vaccine for Children program funding.
  - k) Medicaid CY (based on FY 2015 expenditures) and CY+1, CY+2, CY+3 outlays (Medicaid - Outlays (CL) exclude CDC Vaccine for Children program funding), are based on the FY 2017 Midsession Review.
  - l) CHIP PY outlays (based on FY 2014 expenditures) are based on the FY 2016 Midsession Review.
  - m) CHIP CY (based on FY 2015 expenditures) and CY+1, CY+2, CY+3 outlays (CHIP Total Benefit Outlays with *Children's Health Insurance Program Reauthorization Act* Bonus and Health Care Quality Provisions (CL)), are based on the FY 2017 Midsession Review.
  - n) TANF PY outlays are based on the FY 2016 Midsession Review.
  - o) TANF CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2017 Midsession Review (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs, and excluding the TANF Contingency Fund).
  - p) Foster Care PY outlays are based on the FY 2016 Midsession Review, and reflect the federal share of maintenance payments.
  - q) Foster Care CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2017 Midsession Review, and reflect the federal share of maintenance payments.
  - r) Child Care PY outlays are based on the FY 2016 Midsession Review.
  - s) Child Care CY, and CY+1, CY +2, CY+3 outlays are based on the FY 2017 Midsession Review.
  - t) The "Total" does not represent a true statistical estimate for the agency, and does not include information for TANF.
1. Beginning in FY 2012, in consultation with OMB, HHS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient hospital claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services (i.e., improper payments due to inpatient status reviews) should have been provided as outpatient services. HHS continued this methodology from FY 2013 through FY 2016. This approach is consistent with: (1) Administrative Law Judge and Departmental Appeals Board decisions that directed HHS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B.

HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been properly submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.19 percentage points to 11.00 percent or \$41.08 billion in projected improper payments. Additional information regarding the adjustment factor can be found on pages 166 – 167 of HHS's FY 2012 AFR (available at: [www.wayback.archive-it.org/3922/20131030171234/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171234/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

2. The Medicare Part C and D targets for CY+2 and CY+3 are held constant based on the uncertainty of out-year trends. The targets for CY+3 will be re-evaluated after the FY 2017 reporting period.
3. The Medicare Part D targets for CY+1 and CY+2 were established and published in the FY 2015 AFR. In FY 2016, HHS revised the Medicare Part D methodology as described in *Section 11.31*, but HHS retained the program's previously established reduction targets.
4. HHS calculated and is reporting the national Medicaid improper payment rate based on measurements that were conducted in FYs 2014, 2015, and 2016. The national Medicaid component improper payment rates are: Medicaid FFS: 12.42 percent and Medicaid managed care: 0.25 percent. The Medicaid eligibility component improper payment rate is held constant at the FY 2014 reported rate of 3.11 percent as described in *Section 11.40*.
5. HHS calculated and is reporting the national CHIP improper payment rate based on measurements that were conducted in FYs 2014, 2015, and 2016. The national CHIP component improper payment rates are: CHIP FFS: 10.15 percent and CHIP managed care: 1.01 percent. The CHIP eligibility component improper payment rate is held constant at the FY 2014 reported rate of 4.22 percent as described in *Section 11.50*.
6. The TANF program is not reporting an error rate for FY 2016. Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. Please see *Section 11.60* for additional information on statutory limitations to establishing a TANF improper payment measurement.
7. The *Child Care and Development Block Grant Act of 2014* (CCDBG) reauthorized the Child Care and Development Fund program for the first time since 1996. HHS measures one-third of the Child Care grantees each year, which is called a reporting cohort. In FY 2016, HHS established a slight increase in the improper payment target rates to accommodate all reporting cohorts' implementation of the sweeping policy and procedure changes under the new CCDBG statute. While the FY 2016 improper payment rate declined from FY 2015, HHS anticipates increases in errors as states implement new policies. Fewer reporting states implemented new policy and procedure changes than anticipated for the FY 2016 report. Many states also requested and received waiver extensions for requirements under the CCDBG statute. HHS granted these requests for all but the health and safety requirements. New CCDF regulations released in September 2016 will have a great impact on states as they promulgate and implement new policies and procedures. Future targets have been reduced slightly from earlier projections, but still allow for an increase over the next three years as additional federal regulations are developed and implemented along with the CCDBG's requirements. Future targets may be adjusted as well, depending on future performance.

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**Table 1B**  
**Improper Payment Reporting for Superstorm Sandy Programs**

FY 2015 – FY 2019 (in Millions) <sup>Note (1)</sup>

Program or Operating Division	PY Outlays \$	PY IP %	PY IP \$	CY Outlays \$	CY IP %	CY IP \$	CY Over payment \$	CY Under payment \$	CY Net IP %	CY Net IP \$	CY+1 Est. Outlays \$	CY+1 IP %	CY+1 IP \$	CY+2 Est. Outlays \$	CY+2 IP %	CY+2 IP \$	CY+3 Est. Outlays \$	CY+3 IP %	CY+3 IP \$
ACF Head Start	16.38	0.38	0.0616	71.78	0	0	0	0	0	0	2.91	0.38 Note (2)	0.011	N/A	N/A	N/A	N/A	N/A	N/A
ACF Social Services Block Grant	209.14	0.22	0.464	198.33	0.68	1.35	1.35	0.00001	0.68	1.35	60.56 Note (3)	0.67	0.41	N/A	N/A	N/A	N/A	N/A	N/A
ACF <i>Family Violence Prevention and Services Act</i>	0.893	0.89	0.00794	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ASPR Research	1.55	0	0	3.055	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CDC Research	4.6	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SAMHSA	1.32	1.38	0.0182	1.279	0.047	0.0006	0.0006	0	0.05	0.0006	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
NIH Research	38.60	2.29	0.885	12.35	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SUB-TOTAL Note (4)	272.483	0.53	1.437	286.79	0.47	1.35	1.35	0.00001	0.47	1.35	63.47	0.66	0.42	N/A	N/A	N/A	N/A	N/A	N/A

## 9.20 Accompanying Improper Payment Reporting for Superstorm Sandy Programs Notes

1. Table 1B does not include current or future information for programs where all of the funds were expended or will be expended, and are noted by a “N/A” in the relevant cells.
2. ACF Head Start improper payments during previous years resulted from unintentional human error in recipient record-keeping, some level of which may continue in the future. Therefore, HHS anticipates that it will not continue to report a 0 percent error rate in the future, and has set a reduction target of 0.38 percent, which is the highest previously reported rate for the program.
3. ACF Social Services Block Grant CY+1 outlays are based on the remaining grant award amounts (minus drawdowns) as of June 30, 2016, and grants will end on September 20, 2017.
4. The “Total” does not represent a true statistical estimate for the agency.

**Table 1C**  
**Improper Payment Reporting for All Programs**  
 FY 2015 - FY 2019 (in Millions)

Name	PY Outlays \$	PY IP %	PY IP \$	CY Outlays \$	CY IP %	CY IP \$	CY Over payment \$	CY Under payment \$	CY Net IP %	CY Net IP \$	CY+1 Est. Outlays \$	CY+1 IP %	CY+1 IP \$	CY+2 Est. Outlays \$	CY+2 IP %	CY+2 IP \$	CY+3 Est. Outlays \$	CY+3 IP %	CY+3 IP \$
Sub-Total of OMB- Determined Risk- Susceptible Programs from Table 1A	882,173.48	10.18	89,775.39	967,276.30	10.02	96,940.51	89,744.65	7,195.84	8.53	82,548.81	1,089,568.15	9.26	100,871.02	1,119,011.39	7.86	87,952.33	1,214,564.21	7.41	90,056.34
Sub-Total of Superstorm Sandy Programs from Table 1B	272.483	0.53	1.437	286.79	0.47	1.35	1.35	0.00001	0.47	1.35	63.47	0.66	0.42	N/A	N/A	N/A	N/A	N/A	N/A
<b>TOTAL ALL PROGRAMS</b> Note (1)	882,445.963	10.17	89,776.827	967,563.09	10.02	96,941.86	89,746.00	7,195.84	8.53	82,550.16	1,089,631.62	9.26	100,871.44	1,119,011.39	7.86	87,952.33	1,214,564.21	7.41	90,056.34

### 9.30 Accompanying Improper Payment Reporting for All Programs Notes

1. The "Total" does not represent a true statistical estimate for the agency.

### 10.0 Improper Payment Root Cause Categories

Appendix C to OMB Circular A-123 requires the reporting of improper payment root causes by agencies with high-risk programs. The following tables (2A and 2B) display HHS's improper payment root causes for FY 2016 for each high-risk program. There is a separate column for each program. The tables include categories of improper payments and the amount of overpayment or underpayment associated with each improper payment category. Additional information on the root causes and corrective actions, for each high-risk program can be found in each program-specific reporting section.

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**Table 2A**  
**Improper Payment Root Cause Category Matrix for OMB-Determined Risk-Susceptible Programs**  
FY 2016 (in Millions)

Reason for Improper Payment		Medicare FFS		Medicare Part C		Medicare Part D		Medicaid		CHIP		Foster Care		Child Care	
		Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue															
Inability to Authenticate Eligibility								\$10,184.45	\$286.99	\$363.09	\$4.03				
Failure to Verify:	Death Data							\$109.68		\$2.66					
	Financial Data														
	Excluded Party Data							\$21.87		\$0.37					
	Prisoner Data														
	Other Eligibility Data (explain)														
Administrative or Process Error Made by:	Federal Agency														
	State or Local Agency							\$22,686.77	\$244.47	\$310.80	\$1.64	\$46.50	\$1.18	\$92.69	\$15.53
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	\$4,405.18	\$1,234.55		\$4,698.27		\$733.09	\$338.48		\$2.70	\$0.07				
Medical Necessity		\$8,131.99	\$5.17					\$0.23		\$0.08					
Insufficient Documentation to Determine		\$27,307.75		\$11,484.39		\$1,660.84		\$2,409.24		\$52.37				\$132.52	
Other															
TOTAL		\$39,844.92	\$1,239.72	\$11,484.39	\$4,698.27	\$1,660.84	\$733.09	\$35,750.72	\$531.46 Note (1)	\$732.07	\$5.74 Note (1)	\$46.50	\$1.18	\$225.21	\$15.53

## 10.10 Accompanying Improper Payment Root Cause for OMB-Determined Risk-Susceptible Programs Notes

1. The total Medicaid and CHIP underpayments in Table 2A are greater than the underpayment totals displayed in Table 1A, which excludes underpayments that may have also been counted as overpayments.

**Table 2B**  
**Improper Payment Root Cause Category Matrix for Superstorm Sandy Programs**  
 FY 2016 (in Millions)

Reason for Improper Payment		ACF Head Start		ACF Social Services Block Grant		ASPR Research		SAMHSA		NIH Research	
		Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue											
Inability to Authenticate Eligibility											
Failure to Verify:	Death Data										
	Financial Data										
	Excluded Party Data										
	Prisoner Data										
	Other Eligibility Data (explain)										
Administrative or Process Error Made by:	Federal Agency										
	State or Local Agency			\$0.00001	\$0.00001			\$0.0006			
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)			\$0.28							
Medical Necessity											
Insufficient Documentation to Determine				\$1.07							
Other											
<b>TOTAL</b>		\$0.00	\$0.00	\$1.35	\$0.00001	\$0.00	\$0.00	\$0.0006	\$0.00	\$0.00	\$0.00



## 11.0 Program-Specific Reporting Information

### 11.10 Medicare FFS (Parts A and B)

#### 11.11 Medicare FFS Statistical Sampling Process

Medicare FFS uses the Comprehensive Error Rate Testing (CERT) program to calculate the improper payment estimate. The CERT program considers any claim paid when it should have been denied or was paid in the wrong amount (including both overpayments and underpayments) to be an improper payment. To meet this objective, a stratified random sample of Medicare FFS claims is reviewed to determine if claims were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or a partial improper payment, depending on the error category. Approximately 50,000 claims were sampled during the FY 2016 report period. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample reflects all claims processed by the Medicare FFS program during the report period. Additional information on the Medicare FFS improper payment methodology can be found on pages 166 – 167 of HHS's FY 2012 AFR, available at: [www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

The Medicare FFS gross improper payment estimate for FY 2016 is 11.0 percent or \$41.08 billion. The FY 2016 net improper payment estimate is 10.33 percent or \$38.61 billion. The decrease from the prior year's reported error estimate of 12.09 percent was driven by a reduction in improper payments for inpatient hospital claims. However, improper payments for home health and Inpatient Rehabilitation Facility (IRF) claims were the major contributing factors to the FY 2016 Medicare FFS improper payment rate. While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.

- Insufficient documentation to support medical necessity for home health claims continues to be prevalent, despite the decrease from 58.95 percent in FY 2015 to 42.01 percent in FY 2016.
- Medical necessity (i.e., the services billed were not medically necessary) was the major error reason for IRF claims. The improper payment rate for IRF claims increased from 45.50 percent in FY 2015 to 62.39 percent in FY 2016.

#### 11.12 Medicare FFS CAP

The primary cause of improper payments is lack of documentation to support the services or supplies billed to Medicare, or missing or insufficient documentation errors (66.47 percent). The other causes of improper payments are medical necessity errors (19.81 percent), and administrative or process errors made by other party (13.73 percent).

HHS is committed to reducing improper payments in its programs. HHS uses data from the CERT program and other sources of information to address improper payments in the Medicare FFS program through various corrective actions. While some corrective actions have been implemented, others are in the early stages of implementation. These focused corrective actions will have a larger impact over time as they become integrated into business operations.

To reduce improper payments within Medicare FFS, HHS is implementing a number of measures that focus on prevention. HHS's corrective actions include policy clarifications and simplifications, when appropriate, and more individualized education through smaller probe reviews, followed by specific education based on the findings of these reviews (generally referred to as Probe and Educate reviews). HHS is also committed to exploring

opportunities to implement prior authorization and pre-claim review programs. In addition to helping educate providers and suppliers and decrease the number of appeals, prior authorization and pre-claim review programs also help reduce improper payments.

Of particular importance are corrective actions that focus on specific service areas with high error rates such as home health and IRF claims. HHS believes implementing targeted corrective actions in these areas will have a considerable effect in preventing and reducing improper payments.

- HHS continues to implement corrective actions to address program payment vulnerabilities related to home health services, including errors resulting from insufficient or missing documentation to support the beneficiary's eligibility for home health services and/or for skilled services. Home health corrective actions include: policy revisions; a pre-claim review demonstration; Probe and Educate reviews; and establishing a home health recovery auditor contractor.
  - HHS issued a final rule, CMS-1611-F (79 FR 66032, November 6, 2014) to update Medicare's Home Health Prospective Payment System payment rates and wage index for calendar year 2015. In this rule, HHS finalized changes to the face-to-face encounter requirements for home health episodes beginning on or after January 1, 2015. Specifically, HHS amended the HHA regulation to remove the requirement for documentation of a face-to-face visit to be provided in a prescribed encounter narrative. However, HHS maintained the requirement for a face-to-face visit to have occurred as part of the certification of patient eligibility for the benefit. Now reviewers should consider documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) to determine patient eligibility for the home health service.
  - To assist with documenting the home health face-to-face encounter, HHS completed, as part of the *Paperwork Reduction Act*, the required public comment periods in FY 2016 for a voluntary paper and electronic clinical template for ordering physicians (80 FR 80771, December 28, 2015). The template will help physicians capture the information needed to complete the face-to-face encounter documentation. This template is in the form of a progress note and will become part of the medical record.
  - In FY 2016, HHS began implementing a three-year Pre-Claim Review Demonstration for Home Health Services. Implementation began August 3, 2016, in Illinois. Based on early information from Illinois, HHS believes additional education efforts would be helpful before expanding the demonstration to other states. The start dates for Florida, Texas, Michigan, and Massachusetts have not been announced; however, HHS will provide at least 30 days' notice on its website prior to beginning this demonstration in any state. The demonstration tests whether: 1) pre-claim review improves methods for the identification and investigation of Medicare fraud occurring among HHAs, and 2) the demonstration helps reduce expenditures while maintaining or improving quality of care.
  - On October 1, 2015, HHS's MACs began pre-payment reviews of home health claims for episodes beginning on or after August 1, 2015 that are designed to help HHAs understand the new patient certification requirements. Specifically, HHS's MACs use a Probe and Educate strategy to review five home health claims for every HHA and provide education and/or training if needed.
  - During FY 2016, HHS continued the procurement for a new Medicare FFS Recovery Audit Contractor (RAC) to identify and correct improper payments for home health claims. HHS expects to award the new Home Health RAC contract in early FY 2017.
- Additionally, HHS focuses on addressing IRF payment errors resulting from missing or insufficient medical record documentation to support medical necessity for therapy programs, as well as addressing therapy services provided in other settings.

- HHS issued a final IRF Prospective Payment System (PPS) rule, CMS-1608-F (79 FR 4587, August 6, 2014), which required IRFs to record and report to HHS how much and what type of therapy (that is, Individual, Concurrent, Group, and Co-Treatment) patients receive in each therapy discipline in the IRF setting. HHS will utilize this data for potentially informing future IRF rulemaking.
- There are annual dollar limits to the outpatient therapy services (known as therapy caps) that a Medicare beneficiary can receive each year, though there are exceptions to the therapy cap for reasonable and necessary therapy services. *The Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) extended the therapy cap exception process through December 31, 2017. MACRA also eliminated the requirement for manual medical review of all claims over the \$3,700 thresholds and instead allows a targeted review process for services.
- In FY 2016, HHS tasked the Supplemental Medical Review Contractor (SMRC) with performing medical review on a post-payment basis for IRF services and other therapy services provided in various settings. The SMRC selects these other therapy claims for review based on:
  - Providers with a high percentage of patients receiving therapy beyond the threshold as compared to their peers during the first year of MACRA; and
  - Therapy provided in SNFs; therapists in private practice; and outpatient physical therapy, speech-language pathology providers, or other rehabilitation providers. Of particular interest in this medical review process will be the evaluation of the number of units or hours of therapy provided in a day.

In FY 2016, the Medicare FFS improper payment rate decreased due to the successes of the corrective actions to address improper payments for inpatient hospital services outlined below. As a result, the improper payment rate for inpatient hospital claims decreased from 6.18 percent in FY 2015 to 3.85 percent in FY 2016.

- HHS finalized updates to the Hospital Outpatient Prospective Payment System (“Two Midnight”) rule (CMS-1633-FC, 80 FR 70298, November 13, 2015) regarding when hospital admissions are appropriate for payment under Medicare Part A. At the same time, HHS notified the public of two upcoming changes in education and enforcement strategies.
  - Beginning on October 1, 2015, the Quality Improvement Organizations (QIOs) assumed responsibility to conduct initial patient status reviews to determine the appropriateness of Part A payments for short stay hospital claims. From October 1, 2015 through December 31, 2015, short stay hospital reviews conducted by the QIOs were based on Medicare’s payment policies in effect at the time.
  - Beginning on January 1, 2016, QIOs began conducting patient status reviews in accordance with policy changes finalized in the Hospital Outpatient Prospective Payment System rule (CMS-1633-FC, 80 FR 70298, November 13, 2015) that were effective for calendar year 2016.

HHS also leverages prior corrective action successes in other service areas such as inpatient hospital services; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and certain non-emergent services by educating providers on policies and exploring opportunities to implement prior authorization models.

- During FY 2016, HHS continued the procurement for a new Medicare FFS RAC to identify and correct improper payments for claims for DMEPOS and Hospice Services. The RAC will review all applicable claims types through the appropriate review methods and work with HHS and the MACs to adjust claims to recoup overpayments and correct underpayments. HHS expects to award the new RAC contract in early FY 2017.
- Building on the success of the Power Mobility Device (PMD) prior authorization demonstration, HHS issued a DMEPOS prior authorization final rule in FY 2016 (CMS-6050-F, 80 FR 81674, December 30, 2015) that establishes a prior authorization program for certain DMEPOS items that are frequently subject

to unnecessary utilization. The rule defines unnecessary utilization and establishes a list of DMEPOS items that could be subject to prior authorization before payment is made. HHS expects to begin implementation in FY 2017.

- HHS continues to expand the use of prior authorization in the Medicare FFS program.
  - On September 1, 2012, HHS instituted a prior authorization demonstration program in seven states for PMDs. Prior authorization reviews were performed timely and feedback from the industry and beneficiaries has been largely positive. HHS expanded the demonstration to an additional 12 states (Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington) effective October 1, 2014, bringing the total number of states participating in the demonstration to 19. In FY 2015, HHS also extended the demonstration to August 31, 2018. This demonstration project appears to have led to a decrease in the expenditures for PMDs in both the demonstration and non-demonstration states. Based on claims processed as of December 31, 2015, monthly expenditures for the PMD codes included in the demonstration project decreased from \$12 million in September 2012 to \$3 million in December 2015 in the original seven demonstration states, \$10 million in September 2012 to \$3 million in December 2015 in the 12 additional expansion states, and \$10 million in September 2012 to \$3 million in December 2015 in the non-demonstration states.
  - In December 2014, HHS implemented a prior authorization model for repetitive, scheduled non-emergent ambulance transport occurring on or after December 15, 2014 in New Jersey, Pennsylvania, and South Carolina. On January 1, 2016, in accordance with Section 515 of MACRA, HHS expanded the prior authorization model for repetitive scheduled non-emergent ambulance transports to five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia. Prior to implementing the model, spending on repetitive, scheduled non-emergent ambulance transports in the model states averaged \$18.9 million per month. Based on data from the program's first year, spending decreased in the initial states to an average of \$5.4 million per month.
  - In April 2015, HHS implemented a prior authorization model for non-emergent hyperbaric oxygen therapy in Michigan, Illinois, and New Jersey to test whether prior authorization reduces expenditures while maintaining or improving quality of care for certain non-emergent services. In FY 2016, HHS continued this prior authorization model for non-emergent hyperbaric oxygen therapy in these three states. This project will also help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before rendering services and paying claims.

In addition to these initiatives, HHS has implemented additional efforts to reduce improper payments in the Medicare FFS program that span multiple service areas and address the root causes of improper payments as outlined below.

### **Corrective Actions to Address Root Causes:**

#### ***Root Cause: Administrative or Process Errors Made by Other Party***

- **Automated Edits:** Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, HHS relies on automated edits to identify many inappropriate claims. HHS designed its systems to detect anomalies on the face of the claims, and through these efforts, HHS prevents payment for many erroneous claims. HHS uses the National Correct Coding Initiative (NCCI) to stop claims that never should be paid. For example, this program prevents payments for services such as a hysterectomy for a man or a prostate exam for a woman. The use of the NCCI edits saved the Medicare program \$700.66 million in FY 2015. HHS will report FY 2016 savings from the use of the NCCI edits in the FY 2017 AFR.

- **Provider and Supplier Screening:** The *Affordable Care Act* requires HHS to revalidate all existing Medicare providers and suppliers. All Medicare providers and suppliers enrolled prior to the new screening requirements becoming effective were sent revalidation notices by March 23, 2015. HHS is revalidating all 1.6 million existing Medicare providers and suppliers to ensure that only qualified and legitimate providers and suppliers deliver health care items and services to Medicare beneficiaries. These revalidation efforts alone resulted in approximately 378,500 deactivations as well as the revocation of approximately 24,400 providers and suppliers billing privileges as of September 30, 2016.
- **Healthcare Fraud Prevention Partnership (HFPP):** HHS continues to build the HFPP, a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse. During FY 2016, HFPP membership grew from 43 to 69 partner organizations from the public and private sectors, including federal and state partners, private payers, associations, and law enforcement organizations. HFPP members exchange data, information and anti-fraud practices in an effort to prevent and detect fraud across all payers.
- **Medical Review Strategies:** HHS and its contractors develop medical review strategies using the improper payment data to ensure the areas of highest risk and exposure are targeted. HHS requires its Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in certain error prone claim types, such as home health, hospital outpatient, and SNF claims.
- **Overpayment Recoveries Related to Regulatory Provisions:** In CMS 6037-F, "Medicare Program: Reporting and Returning of Overpayments" (81 FR 7654, February 12, 2016), HHS codified rules that addressed the responsibilities of providers and suppliers to identify, report, and return any Medicare Part A or Part B overpayment.

**Root Cause: Medical Necessity and Insufficient Documentation to Determine**

- **Medical Review Strategies:** HHS contracted with the SMRC to perform medical reviews focused on vulnerabilities identified by HHS data analysis, the CERT program, professional organizations, and federal oversight agencies. The contractor evaluates medical records and related documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules. In FY 2016, the SMRC performed post payment reviews on IRFs, SNF therapy services, chiropractic services, Medicare Part B drugs, and ophthalmology services. The results of these reviews are used to improve billing accuracy.
- **Medical Review Strategies:** HHS continues to allow review contractors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. As a result of stakeholder feedback, in February 2014 HHS announced a number of changes to the Medicare FFS RAC program that would take effect with the new contract awards. Due to the delay in the new contract awards, HHS included several of the changes in the current RACs' contracts. HHS believes that these improvements will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency. For further information on these changes, refer to [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Recovery-Audit-Program-Enhancements11-6-15-Update-.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Recovery-Audit-Program-Enhancements11-6-15-Update-.pdf).
- **Medical Review (MR) Accuracy Award Fee Metric:** Beginning in FY 2014, HHS included the MR Accuracy Award Fee Metric in the Award Fee Plan for MACs that process Part A and Part B claims and DME claims for Medicare FFS beneficiaries. The MR Accuracy Award Fee Metric measures the accuracy of the MAC's complex medical review decisions. HHS believes this project assists with consistent medical review decisions across MACs, leading to uniform education to providers on medical necessity and insufficient documentation improper payments. HHS is considering expanding this project to the MAC

redetermination appeal units to ensure consistent medical review decisions are made at the MAC redetermination appeal level.

- **Provider Billing Self-review:** HHS issues Comparative Billing Reports (CBRs) to help Medicare Part B providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements that enable these providers to examine their billing patterns compared to their peers in the state and across the nation.
- **Provider Billing Self-review:** HHS launched a Provider Billing Review Evaluation in one MAC jurisdiction in FY 2016 to help Part B providers analyze their coding and billing practices by expanding the self-service exchange of information beyond the transaction-based activities of claims, eligibility, medical review, prior authorization, and payment to now include utilization data and information designed to support Part B providers' awareness and compliance. In addition, the system prompts users to use self-service educational materials that will be tracked via web analytics.

### 11.13 Medicare FFS Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure it needs to reduce improper Medicare FFS payments to the targeted levels. HHS's systems have the ability to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with national rates. The systems at both the Medicare contractor level and the HHS level are tied together by a high-speed secure network that allows rapid transmission of large data sets between systems. In addition, HHS continuously reviews opportunities for centralizing the development and implementation of automated edits based on national coverage determinations, medically unlikely units billed, and other relevant parameters to prevent improper payments on a prepayment basis.

### 11.14 Medicare FFS Statutory or Regulatory Barriers That Could Limit Corrective Actions

HHS has limited authority to conduct prior authorization on services that account for a large portion of Medicare FFS improper payments. Currently, HHS can only conduct prior authorization for a limited set of DMEPOS items, advanced imaging, spinal subluxation, and non-emergency ambulance transport services, which generally account for a small portion of the Medicare FFS improper payments. For example, in December 2015, HHS promulgated a final rule that will implement prior authorization for a limited set of DMEPOS items. Specifically, Section 1834(a)(15) of the *Social Security Act* authorizes the Secretary to develop and periodically update a list of DMEPOS items determined to be subject to unnecessary utilization and to develop a prior authorization process for these items. Additionally, recent legislation, the *Protecting Access to Medicare Act of 2014* and MACRA, expanded prior authorization authorities to advanced imaging, spinal subluxation, and non-emergent ambulance transport. Because of these limited authorities, the *FY 2017 President's Budget* proposed amending the *Social Security Act* to authorize the Secretary to select any items or services for prior authorization without rulemaking where the items or services involve high cost, high utilization, patient risk, and/or high improper payment rates.

### 11.20 Medicare Advantage (Part C)

#### 11.21 Medicare Advantage Statistical Sampling Process

The FY 2016 Medicare Part C gross improper payment estimate is 9.99 percent or \$16.18 billion. The FY 2016 net improper payment estimate is 4.19 percent or \$6.79 billion. The increase from the prior year's reported error estimate was due to volatility in underlying payment methodology and to lack of improvement in validity of plan-reported diagnoses.

The Part C methodology estimates errors resulting from incorrect beneficiary risk scores. The primary component of a beneficiary's risk score is based on clinical diagnoses submitted by plans. If the diagnoses submitted to HHS are not supported by medical records, the risk scores will be inaccurate and result in payment errors. The Part C estimate is based on medical record reviews conducted under HHS's annual Risk Adjustment Data Validation (RADV) process, where unsupported diagnoses are identified and corrected risk scores are calculated.

The FY 2016 methodology consisted of the following steps:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in calendar year 2014, where the strata are high, medium, and low risk scores;
- Medical record review of the diagnoses submitted by plans for the sampled beneficiaries;
- Calculation of beneficiary-level payment error for the sample; and
- Extrapolation of the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount.

## 11.22 Medicare Advantage CAP

The root causes of FY 2016 Medicare Part C improper payments resulted from errors due to missing or insufficient documentation (70.97 percent) and administrative or process errors made by other party (the Medicare Advantage [MA] organizations) (29.03 percent).

### Corrective Actions to Address Root Causes:

**Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party**  
HHS has implemented four key corrective actions to address the Part C improper payment rate:

- **Contract-Level Audits:** HHS is proceeding with the RADV contract-level audits to recover overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. RADV audits are HHS's primary corrective action to recoup improper payments. HHS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted by plans for payment. Payment recovery for the pilot audits has been completed and totaled \$13.7 million (\$5.4 million was recovered in FY 2014, \$5.0 million in FY 2013, and \$3.4 million in FY 2012)<sup>27</sup>. RADV audits of payment year 2011, which began in FY 2014, will be the first HHS reviews to recoup funds based on extrapolated estimates. In addition, during FY 2016, payment year 2012 audits continued and payment year 2013 audits were initiated.
- **Overpayment Recoveries Related to Regulatory Provisions:** In CMS-4159-F, "Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" (79 FR 29843, May 23, 2014), HHS codified the *Affordable Care Act* requirement that MA organizations report and return overpayments that they identify. In CMS-1613-F, "The Calendar Year 2015 Outpatient Prospective Payment System and Ambulatory Surgical Center Rule" (79 FR 66769, November 10, 2014), HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by an MA organization. In FY 2016, MA organizations reported and returned approximately \$317 million in self-reported overpayments.
- **Recovery Audit Contractor:** As part of the procurement process to secure a Medicare Part C RAC, HHS posted a Request for Quote in June 2014; however, no responses were received from that solicitation. More recently, a Request for Information was posted in December 2015 to solicit additional feedback

<sup>27</sup> Values do not total due to rounding.



from industry regarding this program. HHS received several submissions in response to the announcement. HHS continues its implementation efforts and anticipates awarding a contract in 2017.

- Training: HHS continued its national fraud, waste, and abuse in-person and webinar training sessions for MA plans.

### **11.23 Medicare Advantage Information Systems and Other Infrastructure**

HHS has the information systems and other infrastructure needed to reduce improper Medicare Part C payments. HHS uses the following internal Medicare systems to make and validate the Medicare Part C payments: the Medicare Beneficiary Database; the Risk Adjustment System, the Health Plan Management System; and the Medicare Advantage Prescription Drug (MARx) payment system.

### **11.24 Medicare Advantage Statutory or Regulatory Barriers that Could Limit Corrective Actions**

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### **11.30 Medicare Prescription Drug Benefit (Part D)**

#### **11.31 Medicare Prescription Drug Benefit Statistical Sampling Process**

The Medicare Part D gross improper payment estimate for FY 2016 is 3.41 percent or \$2.39 billion. The FY 2016 net improper payment estimate is 1.32 percent or \$927.75 million. The FY 2016 Part D Payment Error Rate measures payment error related to prescription drug event data. The primary factor that drove the program's decrease from the prior year's reported error estimate was a change in the program's methodology.

The methodology for calculating the FY 2016 Part D error estimate has been revised from prior years, when HHS reported a Part D composite rate consisting of four components: Payment Error Related to Low Income Subsidy Status (PELS); Payment Error Related to Medicaid Status (PEMS); Payment Error Related to Prescription Drug Event Data Validation (PEPV); and Payment Error Related to Direct and Indirect Remuneration (PEDIR).

With OMB's approval, for FY 2016 and subsequent years, the Part D error estimate measures only one component, the PEPV, which is the area where the majority of error for the program exists. The three other previously measured components – PELS, PEMS, and PEDIR – pose very little risk of payment error to the government. Over the years of measurement, the error estimates for these components as demonstrated in previous measurement cycles significantly decreased, such that the effort and resources required to measure them were no longer cost effective. A description of the previous methodology is on pages 173 – 175 of HHS's FY 2012 AFR ([www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

#### **11.32 Medicare Prescription Drug Benefit CAP**

The root causes of the FY 2016 Part D improper payments are missing or insufficient documentation (69.38 percent) and administrative or process error made by other party (30.62 percent).



## Corrective Actions to Address Root Causes:

### *Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party*

HHS conducted the following corrective actions to address errors:

- **Training:** HHS continued its national training sessions for Part D sponsors on payment and data submission. HHS also continued its national fraud, waste, and abuse in-person and webinar training sessions for Part D sponsors.
- **Outreach:** HHS continued formal outreach to plan sponsors for invalid/incomplete documentation. HHS distributed Plan Sponsor Summary Reports to all plans participating in the national payment error estimate. This report provided feedback on their submission and validation results against an aggregate of all participating plan sponsors.
- **Overpayment Recoveries Related to Regulatory Provisions:** HHS codified the *Affordable Care Act* requirement that Part D sponsors report and return overpayments that they identify. HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by a Part D sponsor (See *Section 11.22* for more information on the rules). In FY 2016, Part D sponsors reported and returned approximately \$9.5 million in self-reported overpayments.

## 11.33 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Medicare Part D payments. HHS uses the following internal Medicare systems to make and validate the Medicare Part D payments: the Medicare Beneficiary Database, the Risk Adjustment System, the Health Plan Management System, the MARx payment system, and the Integrated Data Repository.

## 11.34 Medicare Prescription Drug Benefit Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS lacks specific statutory authority to require the submission of medical records from providers in connection with an investigation or audit of drugs paid under the Medicare Part D program, which could affect HHS's ability to reduce improper payments in the program.

## 11.40 Medicaid

### 11.41 Medicaid Statistical Sampling Process

The national FY 2016 Medicaid improper payment rate is based on measurements conducted in FYs 2014, 2015, and 2016. Medicaid improper payments are estimated on a federal FY basis and measure three component improper payment rates: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components. The eligibility component measurement is currently "on hold" as described in the eligibility component section below.

The Payment Error Rate Measurement (PERM) program uses a 17-state three-year rotation for measuring Medicaid improper payments. To see how HHS grouped states into three cycles, refer to pages 177 – 179 of HHS's FY 2012 AFR ([www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

***FFS and Managed Care Component***

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. The FFS sample size was between 292 and 966 claims per state and the managed care sample size was between 230 and 298 payments per state. The sample sizes were based on each state's historical FFS and managed care improper payment rate data. When a state's FFS component or managed care component accounted for less than 2 percent of the state's total Medicaid expenditures, the state's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred in five states.

***Eligibility Component***

In light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the *Affordable Care Act*, HHS is updating the eligibility component measurement methodology and related PERM program regulation to reflect these changes. HHS published a PERM Notice of Proposed Rule-Making (81 FR 40596, June 22, 2016) in FY 2016 to update the PERM eligibility component.

In August 2013 and October 2015, HHS released guidance announcing temporary changes to PERM eligibility reviews. For FYs 2015 through 2018, HHS will not conduct the eligibility measurement component of PERM, but will hold the eligibility component's error rate constant at the FY 2014 reported rate of 3.11 percent.

In place of the FYs 2015 through 2018 PERM eligibility reviews, all states are required to conduct eligibility review pilots that provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors.

***Calculations and Findings***

The national Medicaid program improper payment rate represents the combination of each state's Medicaid FFS, managed care, and eligibility improper payment rates. In addition, individual state component improper payment rates are combined to calculate the national component improper payment rates. National component improper payment rates and the Medicaid program improper payment rate are weighted by state size, so that a state with a \$10 billion program "counts" 10 times more toward the national rate than a state with a \$1 billion program. A small correction factor ensures that Medicaid eligibility improper payments are not "double counted." Additionally, HHS incorporates state-level improper payment rate recalculations for the states measured in FY 2014 and FY 2015 into the national Medicaid improper payment rate. Subsequent to FY 2015 reporting, eight state-level FFS improper payment rates were recalculated to allow for appeal results and late documentation that was received prior to the cut-off date for claims submitted between July 1, 2013 and June 30, 2014 and are incorporated into FY 2016 improper payment rate reporting.

The national Medicaid gross improper payment estimate for FY 2016 is 10.48 percent or \$36.25 billion. The FY 2016 net improper payment estimate is 10.19 percent or \$35.25 billion. This rate increased from prior years due to an increase in the FFS component, as discussed in *Section 11.42*.

The FY 2016 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 12.42 percent
- *Medicaid managed care*: 0.25 percent

As previously stated, the Medicaid eligibility component improper payment rate is held constant at the FY 2014 rate of 3.11 percent.

### ***Eligibility Review Pilot Findings***

The eligibility review pilots continue to identify vulnerabilities in processes and systems. States then take action to address these vulnerabilities, which is essential to preventing future improper payments and improving verification processes. In the most recent round of pilots, states continued to identify vulnerabilities related to caseworkers or systems not properly establishing income level, although these vulnerabilities did not necessarily always lead to eligibility determination errors. States also identified issues related to failures in sending appropriate notices, delays in processing eligibility determinations, and failing to follow verification plans that outline each state's verification policies and procedures. States are implementing corrective action strategies and focusing on targeted caseworker training, systems fixes and maintaining records as the pilots continue. More information on the pilots can be found at: [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014\\_FY2016EligibilityReviewPilots-.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html).

## **11.42 Medicaid CAP**

States reviewed for the FY 2016 AFR measurement were the same states reviewed in FY 2013. The improper payment rate for these states increased from 5.73 percent in FY 2013 to 8.81 percent in FY 2016, causing an increase in the FY 2016 national Medicaid improper payment rate. The FFS component was the driver of the increase for these states, rising from 3.42 percent to 9.78 percent.

Similar to FY 2014 and FY 2015, the primary reason for the FY 2016 improper payments was errors related to state difficulties bringing systems into compliance with provisions put in place to strengthen program integrity. First, all referring or ordering providers are required to be enrolled in Medicaid or CHIP and claims must contain the referring or ordering National Provider Identifier (NPI) (42 CFR §455.410(b) and 455.440, respectively). Second, states are required to screen providers under a risk-based screening process prior to enrollment (42 CFR §455.450). Finally, the attending provider NPI is required to be submitted on all electronically filed institutional claims (45 CFR §162.1102). While these requirements will ultimately strengthen Medicaid program integrity, it is not unusual to see increases in improper payment rates following the implementation and initial measurement of new requirements because it takes time for states to make the changes required for compliance.

Although all states are included in the improper payment rates, HHS only reviews 17 states each year. In FY 2014, HHS reported a rate reflecting the first 17 states measured under new the requirements. The FY 2015 improper payment rates reflected the second group of 17 states subject to new requirements for a total of 34 states. The FY 2016 rate reflects the measurement of the final group of 17 states subject to new requirements. HHS expects to see a decrease in improper payment rates in following years as states that have implemented corrective actions are measured again.

HHS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. The Department received CAPs from all states with Medicaid programs that were previously measured, and all states measured in FY 2016 are developing CAPs for submission to HHS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. In addition, states also take steps to reduce errors identified during the measurement. HHS also establishes corrective actions to reduce improper payments. For example, HHS is actively engaging with states to address these root causes by: conducting outreach during off-cycle PERM measurement years to address issues identified in CAPs; facilitating national best practice calls to share ideas across states; offering ongoing technical assistance; and providing additional guidance as needed. Additional information on states' and HHS's corrective actions are provided below.

## Corrective Actions to Address Root Causes:

### ***Root Causes: Administrative or Process Errors Made by State or Local Agency and Failure to Verify***

Administrative or process errors made by a states or local agencies and failure to verify mainly consist of errors resulting from state difficulties bringing systems into compliance with new requirements as described above. Improper payments related to non-compliance with these new requirements do not necessarily represent payments to illegitimate providers. Typically, improper payments are cited when information required for payment was missing from the claim or states did not follow appropriate processes for enrolling providers. If the information had been on the claim and the state followed the correct enrollment process, then the claim may have been payable.

Because the Medicaid improper payment rate was primarily driven by these errors, state CAPs focus on systems or process changes to reduce these errors. Specific actions include implementing new claims processing edits, converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program. For example, state Medicaid agencies may rely on Medicare's enrollment and screening of providers and on Medicare's site visits, where the provider is enrolled in Medicare and Medicaid.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS has implemented corrective actions to specifically address compliance with Medicaid provider screening, enrollment, and revalidation efforts to reduce errors related to this category:

- **State Medicaid Provider Screening and Enrollment:** HHS shares Medicare data to assist states with meeting Medicaid screening and enrollment requirements. Specifically, HHS shares the Medicare provider enrollment record via the Provider Enrollment, Chain and Ownership System (PECOS) administrative interface and via data extracts from the PECOS system. HHS also shares Office of the Inspector General (OIG) exclusion data with states. In May 2016, HHS began to offer a data compare service that allows a state to rely on Medicare's screening, in lieu of conducting state screening. Using the data compare service, a state provides an extract of Medicaid provider enrollment data to HHS and then HHS returns information to the state indicating for which providers the state is able to rely on Medicare's screening.
- **Enhanced Assistance on State Medicaid Provider Screening and Enrollment:** HHS provides ongoing guidance, education, and outreach (site visits and technical assistance) to states on federal requirements for Medicaid enrollment and screening. In addition, HHS published the Medicaid Provider Enrollment Compendium in March 2016, which is sub-regulatory guidance designed to assist states in applying the regulatory requirements.
  - **Site Visits:** HHS conducts state site visits to assess provider screening and enrollment compliance, provide technical assistance, and offer states the opportunity to leverage Medicare screening and enrollment activities.
  - **Technical Assistance for Provider Screening and Enrollment:** In FY 2016, HHS procured a contractor to assist with ongoing state technical assistance and process improvement related to provider screening and enrollment. The project will include assessing state compliance with requirements for provider screening and enrollment, conducting a gap analysis, and developing strategic blueprints to assist states with improving processes. In addition, in order to help alleviate state concerns with the cost of completing the Social Security Administration (SSA) Death Master File (DMF) check as part of the provider screening, HHS is working with the SSA to provide the DMF to states. HHS has obtained this data and is developing a secure method for housing and sharing the large volume of sensitive data with states. HHS plans to share this information with states by the end of 2016.

- Medicaid Integrity Institute: HHS offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute. The FY 2016 course schedule included seminars in May and September 2016 that focused exclusively on complying with the provider screening and enrollment requirements. More information on the Medicaid Integrity Institute can be found at: [www.justice.gov/mii](http://www.justice.gov/mii).

**Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party**

State CAPs also include provider communication and education to reduce errors related to these categories. These methods include holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written state policies emphasizing documentation requirements; and performing more provider audits to identify areas of vulnerability and target solutions.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS has implemented additional efforts to lower improper payments rates in these two error categories:

- State Medicaid RAC Programs: By the end of FY 2016, 47 states and the District of Columbia had implemented Medicaid RAC programs to identify and recover overpayments and identify underpayments in their Medicaid programs. However, each state has the flexibility to tailor its RAC program where appropriate with guidance from HHS. For example, two of the states that have implemented Medicaid RAC programs ended their RAC programs when HHS approved an exception because of the high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS. Five states currently have time-limited HHS-approved exceptions to Medicaid RAC implementation due to high managed care penetration or small beneficiary populations.
- Expanded Reviews/Oversight: HHS aligned state Program Integrity Reviews with off-cycle PERM reviews to maintain pressure on states that were previously reviewed to continuously correct errors. During FY 2016, HHS collected information on the status of the PERM CAP completion for states that submitted CAPs related to Medicaid FFS in FY 2015. In FY 2017, HHS will complete its assessment of states' PERM CAP status and provide feedback to states on actions needed to complete their PERM CAP.
- Education: HHS made available a variety of educational toolkits, which include presentations, fact sheets, and booklets that were made specifically for providers or beneficiaries. These educational resources are intended to educate providers, beneficiaries, and other stakeholders in promoting best practices and raising awareness of Medicaid fraud, waste, and abuse. In FY 2016, HHS posted the following new toolkits: Pharmacy Audit & Dispensing Toolkit, Behavioral Health Toolkit, and Medicaid Provider Enrollment Toolkit. HHS also posted a series of program integrity eBulletins, Infographics, Podcasts, and Key Messages and Tips on a variety of topics for providers and beneficiaries. More information on these educational toolkits can be found at: [www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html](http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html).

**Root Cause: Medical Necessity**

Although this is a minor issue seen in a few states, HHS has worked closely with those states to develop corrective actions to address this root cause. State CAPs include:

- System Edits: Adding a system edit to require medical necessity documentation for certain procedures;
- Education: Providing additional provider education to improve clinical record documentation;
- Training: Encouraging facilities to develop and implement a quality assurance plan to bill revenue codes correctly prior to submitting claims; and

- **Expanded Reviews:** Performing independent post-payment reviews to identify any improper or erroneous billing activity.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS has also continued its education efforts, discussed in detail above, to increase state compliance with medical necessity requirements.

### **11.43 Medicaid Information Systems and Other Infrastructure**

Since Medicaid payments occur at the state level, information systems and other infrastructure needed to reduce Medicaid improper payments would need to be implemented at the state level. HHS has encouraged and supported states in their efforts to modernize and improve state Medicaid Management Information Systems (MMIS), which will produce greater efficiencies in areas reflected in the PERM measurement and strengthen program integrity. In addition, HHS has approved enhanced federal funding for nine states to implement predictive analytics technologies that are integrated with state MMIS. Lastly, the state systems workgroup (composed of HHS and state staff representatives) meets regularly to identify and discuss system vulnerabilities and the impact on the measurement of improper payments.

HHS developed a comprehensive plan to modernize the federal Medicaid and CHIP data systems. The primary goal of this plan is to leverage technologies to create an authoritative and comprehensive Medicaid and CHIP data structure so that HHS can provide more effective oversight of its programs. The plan will also result in a reduction of state burden and the availability of more robust data for the PERM program.

HHS also developed the Transformed Medicaid Statistical Information System (T-MSIS) to facilitate state submission of timely claims data to HHS, expand the MSIS dataset, and allow HHS to review the completeness and quality of state Medicaid Statistical Information System submittals in real-time. HHS will use this data for the Medicaid improper payment measurement and to satisfy other HHS requirements. Through the use of T-MSIS, HHS will not only acquire higher quality data, but will also reduce data requests to the states.

As of September 30, 2016, 18 states are live in T-MSIS production, with the remaining states expected to submit data in the T-MSIS file format before the end of calendar year 2016.

### **11.44 Medicaid Statutory or Regulatory Barriers that could limit Corrective Actions**

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

## **11.50 CHIP**

### **11.51 CHIP Statistical Sampling Process**

The national FY 2016 CHIP improper payment rate is based on measurements conducted in FYs 2014, 2015, and 2016. CHIP improper payments are estimated on a federal FY basis and measure three component improper payment error rates: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components. The eligibility component measurement is currently “on hold” as described in the eligibility component section below.

CHIP utilizes the same state sampling process as Medicaid. HHS determined that CHIP can be measured in the same states selected for Medicaid review each FY with a high probability that the CHIP improper payment rate will meet the IPIA required confidence and precision levels. Since CHIP and Medicaid are measured in the same states each year, each state is measured once every three years. For information on how HHS grouped states into three

cycles, refer to page 183 of HHS's FY 2012 AFR ([www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

### ***FFS and Managed Care Component***

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. The FFS sample size was between 299 and 968 claims per state and the managed care sample size was between 68 and 300 payments per state. When a FFS component or managed care component for a state accounted for less than 2 percent of the state's total CHIP expenditures, the state's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred for claims in one state.

### ***Eligibility Component***

In light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the *Affordable Care Act*, HHS is updating the eligibility component measurement methodology and related PERM program regulation to reflect these changes. HHS published a PERM Notice of Proposed Rule-Making (81 FR 40596, June 22, 2016) in FY 2016 to update the PERM eligibility component.

In August 2013 and October 2015, HHS released guidance announcing temporary changes to PERM eligibility reviews. For FYs 2015 through 2018, HHS will not conduct the eligibility measurement component of PERM, but will hold constant at the FY 2014 reported rate of 4.22 percent.

In place of FYs 2015 through 2018 PERM eligibility reviews, all states are required to conduct eligibility review pilots. The eligibility review pilots provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors.

### ***Calculations and Findings***

The national CHIP improper payment rate represents the combination of each state's FFS, managed care, and eligibility improper payment rates. In addition, individual state component improper payment rates are combined to calculate the national component improper payment rates. National component improper payment rates and the CHIP improper payment rate are weighted by state size, so that a state with a \$1 billion program "counts" 5 times more toward the national rate than a state with a \$200 million program. A small correction factor ensures that CHIP eligibility improper payments are not "double counted." Additionally, HHS incorporates state-level improper payment rate recalculations for the states measured in FY 2014 and FY 2015 into the national CHIP improper payment rate. Subsequent to FY 2015 reporting, three state-level FFS improper payment rates were recalculated to allow for appeal results and late documentation that was received prior to the cut-off date for claims submitted between July 1, 2013 and June 30, 2014, and are incorporated into FY 2016 improper payment rate reporting.

The national CHIP gross improper payment estimate for FY 2016 is 7.99 percent or \$737.59 million. The FY 2016 net improper payment estimate is 7.87 percent or \$726.55 million. This rate increased from prior years due to an increase in the FFS component, as discussed in *Section 11.42*.



The FY 2015 national CHIP improper payment rate for each component is:

- *CHIP FFS*: 10.15 percent
- *CHIP managed care*: 1.01 percent

As previously stated, the CHIP eligibility component improper payment rate is held constant at the FY 2014 rate of 4.22 percent.

### ***Eligibility Review Pilot Findings***

Please refer to *Section 11.41* for information on the Medicaid and CHIP eligibility review pilots.

## **11.52 CHIP CAP**

States reviewed for the FY 2016 AFR measurement were the same states reviewed in FY 2013. The improper payment rate for these states increased from 6.76 percent in FY 2013 to 12.42 percent in FY 2016, causing an increase in the FY 2016 national CHIP improper payment rate. The FFS component was the driver of the increase for these states, rising from 6.11 percent to 14.05 percent.

Overall, the largest reason for the FY 2016 errors was related to state difficulties bringing systems into compliance with provisions put in place to strengthen program integrity (as discussed in *Section 11.42*). While these requirements will ultimately strengthen CHIP program integrity, it is not unusual to see increases in improper payment rates following the implementation and initial measurement of new requirements because it takes time for states to make the changes required for compliance.

Although all states are included in the improper payment rates, HHS only reviews 17 states each year. In FY 2014, HHS reported a rate reflecting the first 17 states measured under new the requirements. The FY 2015 improper payment rate reflected the second group of 17 states subject to new requirements for a total of 34 states. The FY 2016 rate reflects the measurement of the final group of 17 states subject to new requirements. HHS expects to see a decrease in improper payment rates in following years as states that have implemented corrective actions are measured again.

HHS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. The Department received CAPs from all states with CHIP programs that were previously measured, and all states measured in FY 2016 are developing CAPs for submission to HHS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. In addition, states also take steps to reduce errors identified during the measurement. HHS also establishes corrective actions to reduce improper payments. For example, HHS is actively engaging with states to address these root causes by: conducting outreach during off-cycle PERM measurement years to address issues identified in CAPs; facilitating national best practice calls to share ideas across states; offering ongoing technical assistance; and providing additional guidance as needed. Additional information on states' and HHS's corrective actions are provided below.

### **Corrective Actions to Address Root Causes:**

#### ***Root Causes: Administrative or Process Errors Made by State or Local Agency and Failure to Verify***

Administrative or process errors made by states or local agencies and failure to verify mainly consist of errors resulting from state difficulties bringing systems into compliance with new requirements as described above. Since the CHIP improper payment rate was primarily driven by these errors, state CAPs focus on systems or process changes to reduce these errors. Specific actions include implementing new claims processing edits,



converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS has implemented corrective actions to reduce errors related to this category. HHS's efforts include allowing states to rely on Medicare's enrollment screening of providers to help prevent PERM-related enrollment errors, sharing Medicare data to assist states with meeting screening and enrollment requirements, and providing ongoing education and outreach to states on federal requirements for enrollment and screening. More detailed information on these activities is provided in *Section 11.42: Medicaid CAP*.

**Root Causes: *Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party***

State CAPs include provider communication and education to reduce errors related to these categories. These methods include holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written state policies emphasizing documentation requirements; and performing more provider audits to identify areas of vulnerability and target solutions.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS has implemented additional efforts to lower improper payment rates in these two error categories. More detailed information on these activities is provided in *Section 11.42: Medicaid CAP*.

**Root Cause: *Medical Necessity***

Although this is a minor issue seen in a few states, HHS has worked closely with those states to develop corrective actions to address this root cause. More detailed information on state and HHS activities can be found in *Section 11.42: Medicaid CAP*.

## 11.53 CHIP Information Systems and Other Infrastructure

Since CHIP payments occur at the state level, information systems and other infrastructure needed to reduce CHIP improper payments would need to be implemented at the state level. Please refer to *Section 11.43: Medicaid Information Systems and Other Infrastructure* for information on HHS and state-led efforts to modernize information and data systems at the national and state level.

## 11.54 CHIP Statutory or Regulatory Barriers that Could Limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

## 11.60 TANF

### 11.61 TANF Statistical Sampling Process

Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an error rate for FY 2016.

### 11.62 TANF CAP

Since TANF is a state-administered program, corrective actions that could help reduce improper payments would have to be implemented at the state level. Since HHS cannot require states to participate in a TANF improper payment measurement, HHS is also unable to compel states to collect the required information to implement and

report on corrective actions. Despite these limitations, HHS has taken the following actions to assist states in reducing improper payments:

- **Single Audit Findings:** HHS works with states to analyze Single Audit material non-compliance findings related to TANF and to implement corrective actions to address these findings.
- **Risk Assessment:** HHS performed a detailed risk assessment of the TANF program to determine susceptibility to significant improper payments. As part of this process, HHS identified potential payment risks at the federal level and is working to mitigate these payment risks.
- **Program Integrity Innovation Pilot:** HHS monitored a TANF Program Integrity Innovation Grant funded from OMB's Partnership Fund for Program Integrity Innovation. The state human service agency grantee in Connecticut conducted a pilot project designed to reduce improper payments and improve administrative efficiency in the state's TANF program. The final report, submitted to HHS in August 2016, includes lessons learned and valuable TANF program integrity information that will be shared with other states.
- **Financial Reporting Improvement:** HHS implemented revisions to the TANF financial reporting form to require states to provide more accurate information about how states are using TANF block grants and meeting their Maintenance-of-Effort obligations. The changes took effect in FY 2015, and include a revised and expanded list of spending categories as well as a change to the accounting method to track actual expenditures that occur in a FY. After adding six new categories, such as child welfare services and Pre-Kindergarten/Head Start and clarifying definitions, the amount initially reported as "other" decreased from 14.7 percent in FY 2014 to 4.0 percent in FY 2015.
- **Final Regulation on Reporting of Electronic Benefit Transfer (EBT) Policies and Practices:** In FY 2016, HHS issued final regulations regarding "State Reporting on Policies and Practices to Prevent the Use of TANF Funds in Electronic Benefit Transfer Transactions in Specified Locations" (81 FR 2092, January 15, 2016). The regulations require states, subject to penalty, to maintain policies and practices that prevent TANF funded assistance from being used in any EBT transaction in specified locations: liquor stores; any casino, gambling casino, or gaming establishment; and any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

### **11.63 TANF Information Systems and Other Infrastructure**

Information systems and other infrastructure needed to reduce TANF improper payments would need to be implemented at the state level. States utilize PARIS, the National Directory of New Hires, and the Income and Eligibility Verification System to minimize improper payments.

### **11.64 TANF Statutory or Regulatory Barriers**

Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement.

### **11.70 Foster Care**

#### **11.71 Foster Care Statistical Sampling Process**

There were no changes to the statistical sampling process for Title IV-E Foster Care in FY 2016. Because current regulations require that programs be reviewed every three years for compliance, this program has taken the review cycle already in place (in compliance with 45 CFR 1356.71, Foster Care Eligibility Reviews) and, with OMB approval, leveraged the existing review cycle to provide a rolling three-year weighted average improper payment rate. Under this approved approach, the Foster Care improper payment estimate is calculated each year using

data collected in the most recent Foster Care Eligibility Review for each state, the District of Columbia, and Puerto Rico. A random sample is drawn from the state's universe of cases having at least one Title IV-E Foster Care maintenance payment during the 6-month period under review (PUR). A review of sampled individual case records identifies the number, nature, and amount of improper payments for each case in the sample. Since each state is reviewed every three years, each year's program improper payments estimate incorporates new review data for about one-third of the states. Examination of the confidence interval around the FY 2016 estimate confirms that the estimate conforms with precision requirements specified in OMB guidance for improper payments reporting. For a more detailed description of the Foster Care improper payments statistical sampling and estimation methodology, refer to pages 189 – 190 of HHS's FY 2012 AFR ([www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs\\_agency\\_financial\\_report\\_fy\\_2012-oai.pdf](http://www.wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf)).

As stated in the FY 2015 AFR, an increasing number of time-limited child welfare waiver demonstration projects will temporarily reduce the number of jurisdictions subject to review and inclusion in the program error rate estimate for the duration of the demonstration projects. These child welfare waiver demonstration projects, authorized by Section 1130 of the *Social Security Act*, waive many program eligibility requirements and allow flexible use of Title IV-E funds to encourage innovative practices and improved child and family outcomes, while ensuring federal cost-neutrality. More information on these demonstration projects—and their impact on the Foster Care error rate calculation—can be found on pages 202-203 of the FY 2015 AFR, available at: [www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf](http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf).

As discussed in the FY 2015 AFR, the program error rate estimate includes data from the most recent review for states with non-statewide waivers, including subsequent reviews conducted on the non-waiver populations in those states following waiver implementation. The state error rate is based on review data for a sample of children receiving traditional Title IV-E services, and the sample rate is applied to overall state payments for those traditional Title IV-E services (i.e., excluding payments for the counties or other populations participating in demonstration projects).

This approach, approved by OMB, maintains continuity in the error rate while also permitting consistent treatment of states with statewide and non-statewide waivers. Following this approach, the FY 2016 estimate is based on review data for 43 states operating traditional Title IV-E programs.<sup>28</sup>

The Foster Care gross improper payment estimate for FY 2016 is 6.89 percent or \$47.68 million. The FY 2016 net improper payment rate is 6.55 percent or \$45.32 million. The primary factor that drove the program's significant increase from the prior year's estimate of 3.65 percent was the performance of two large states that were reviewed in this cycle. These states each previously had error rates below 3 percent, but were found to have error rates of over 20 percent in one instance and over 40 percent in the other instance. Had performance in the two large states remained at their previous levels, the FY 2016 Foster Care error rate would have fallen to 3.61 percent.

## 11.72 Foster Care CAP

All payment errors (100 percent) in the Title IV-E Foster Care Program are administrative or process errors due to incorrect case classification and payment processing by state agencies. The Foster Care program designs CAPs to help states address the payment errors that contribute most to Title IV-E improper payments.

<sup>28</sup> The FY 2016 estimate excludes data for nine states operating statewide waiver demonstrations: six states that were due for a review this year (Arkansas, Colorado, District of Columbia, Indiana, Nebraska, and Oklahoma) and three states that were due for a review in prior years (Florida, Utah, and Wisconsin).

## Corrective Actions to Address Root Cause:

### **Root Cause: Administrative or Process Error Made by State or Local Agency**

Corrective actions have decreased the overall number of payment errors and altered the composition of identified payment errors. For example, following years of work with State Court Improvement Programs and outreach to heighten judicial awareness, judiciary-related errors, once the most prevalent error type, are now among the least common.

**Monitoring and Analysis:** HHS continues to monitor, review results, and analyze the types of payment errors in the Foster Care program to target corrective action planning. In FY 2016, the most common payment errors included:

- Underpayments (14 percent of errors);
- No safety documentation for institutional caregiver staff (14 percent of errors);
- Provider not licensed or approved (13 percent of errors);
- Provider criminal records check not completed (10 percent of errors);
- Other ineligible payments (10 percent of errors); and
- Family not eligible for the Aid to Families with Dependent Children program at time of removal (8 percent of errors).

Together these 6 items account for 69 percent of Foster Care payment errors. Although underpayments represent 14 percent of all errors in terms of frequency, the dollar amount of the underpayments is quite small and, in fact, continued to decrease as the underpayment rate improved from 0.30 percent in FY 2015 to 0.17 percent in FY 2016. In contrast, because of the high cost of institutional care relative to other foster care placements, the dollar amount of improper payments related to cases lacking safety documentation for institutional caregiver staff is high.

In FY 2016, HHS undertook the following key actions to reduce improper payments:

- **Emphasizing Continuous Quality Improvement:** Based on discussions with individual states on review preparation and compliance results, HHS worked with states to emphasize and develop strategies for continuous program improvement with an emphasis on: viewing the quality assurance process as an ongoing process, and developing sound program improvements that support systemic change and sustain the improvement effort.
- **Enhancing Outreach Strategies:** Given that certain types of improper payments, such as those pertaining to foster care provider requirements, occur in a small number of states, HHS implemented outreach strategies tailored to particular state child welfare agencies to provide feedback about specific program performance areas needing improvement and facilitate efforts to correct them. The strategies consisted of enhanced communication and collaboration with these state child welfare agencies to increase their understanding of program compliance requirements and to share strategies that have proven successful in other states.

In addition, HHS continued the following ongoing corrective actions:

- **Conducting Eligibility Reviews and Providing Feedback to State Agencies:** HHS conducts onsite and post-site review activities to validate the accuracy of state claims for reimbursement of payments made on behalf of children and their Foster Care providers. Specific feedback is provided onsite to the state agency to affect proper and efficient program administration and implementation. Furthermore, HHS issues a comprehensive final report that presents findings of the review to the state agency. The final report serves as the basis for the development of a Program Improvement Plan (PIP) for states that exceed the error threshold in a review.

- **Developing PIPs:** HHS requires non-compliant states (those that exceed the error threshold in a review) to develop and execute state-specific PIPs that link corrective actions to the root cause of payment errors. In FY 2016, four of the 16 states reviewed in this cycle were found out of compliance and will complete the PIP. The PIP identifies the specific action steps necessary to target and correct root causes of the errors and each action strategy is required to have a projected completion within one year from the date HHS approved the plan. PIPs are an effective strategy, as reflected in the fact that, since FY 2004 improper payments reporting, only one state has been found not in compliance on an eligibility review conducted following PIP completion.
- **Providing Training and Technical Assistance:** HHS provides training and technical assistance to states to develop and implement program improvement strategies, even when states are not required to develop a PIP. This assistance helps states expand organizational capacity and promote more effective program operations.
- **Conducting Secondary Reviews and Disallowances:** HHS conducts secondary reviews for non-compliant states and takes appropriate disallowances consistent with the review findings (HHS takes disallowances for error findings in both primary and secondary reviews). Four states that were reviewed in the FY 2016 cycle will undergo a secondary review. On a secondary review, if a state is found not in substantial compliance, an extrapolated disallowance is taken. These additional disallowances, in conjunction with the development and implementation of the PIP, serve as a strong incentive to states to improve compliance.

### 11.73 Foster Care Information Systems and Other Infrastructure

HHS uses the Adoption and Foster Care Analysis and Reporting System to draw samples for the regulatory reviews. Utilization of this system reduces the burden on states to draw their own samples, promotes uniformity in sample selection, and employs the database in a practical and beneficial manner. Since Foster Care payments occur at the state level, information systems and other infrastructure needed to reduce Foster Care improper payments would need to be implemented at the state level. States have the option to receive federal financial participation to develop and implement a Comprehensive Child Welfare Information System (CCWIS) in accordance with federal regulations at 45 CFR § 1355.50 through §1355.59. CCWIS project requirements include, among others, the performance of automated program eligibility determinations and bi-directional data exchanges with systems generating the financial payments and claims to assure the availability of needed supporting documentation.

### 11.74 Foster Care Statutory or Regulatory Barriers

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 11.80 CCDF

#### 11.81 CCDF Statistical Sampling Process

The methodology for measuring improper payments uses a case-record review process to determine if child care subsidies were properly paid for services provided to eligible families. The methodology focuses on improper payments made, and enables states to determine the types of errors and their sources. For the CCDF improper payments methodology, please see [www.acf.hhs.gov/occ/resource/program-integrity-and-accountability-improper-payments-error-rate-review](http://www.acf.hhs.gov/occ/resource/program-integrity-and-accountability-improper-payments-error-rate-review).

The current methodology incorporates the following: (a) drawing a statistical sample from a universe of paid cases; (b) measuring improper payments; and (c) requiring states with error rates exceeding 10 percent to submit a CAP.

The error rate methodology and reporting requirements focus on administrative errors associated with client eligibility. The CCDF gross improper payment estimate for FY 2016 is 4.34 percent or \$240.74 million. The FY 2016 net improper payment estimate is 3.78 percent or \$209.68 million.

There were several contributing factors to the decrease in the improper payment rate from 5.74 percent in FY 2015, most notably several states reported significant decreases in the number of cases with improper payments. While all states are updating their policies and procedures to ensure compliance with implementation of the *Child Care and Development Block Grant Act of 2014* (CCDBG), most of the states reporting in FY 2016 (referred to as Year Three states) had not put new policies in place, which potentially kept their error rates lower. HHS anticipates that as states establish new policies, it will likely take some time for states and providers to understand, implement, and follow the new requirements. Therefore, the CCDF's program errors may increase as states implement and are evaluated against the new policies.

### 11.82 CCDF CAP

Administrative or process errors represent approximately 44.95 percent of errors found in the reviews. These errors consist of the failure to apply policy correctly, including:

- Income calculation (16 states);
- Assessing the level of care (7 states); and
- Applying the incorrect payment rate (4 states).

Insufficient Documentation errors account for an estimated 55.05 percent of errors identified in the CCDF improper payment review process. Errors were primarily due to missing or insufficient documentation in the case record. The most frequently cited errors due to missing or insufficient documentation include:

- Verification of work activity (6 states);
- Work or activity schedules to demonstrate need for care (5 states);
- Application forms, redetermination forms, or family files (5 states); and
- Child support verification (3 states).

### Corrective Actions to Address Root Causes:

#### ***Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by or Local Agency***

HHS and states have established corrective actions targeting both error types. States reporting in FY 2016 (Year Three states) plan the following actions to correct both missing or insufficient documentation and administrative process improper payment error causes:

- Conducting training with eligibility staff on CCDF policies and procedures (16 states);
- Conducting ongoing case reviews or audits (10 states);
- Making changes or updates to state eligibility policies and procedures (9 states);
- Upgrading or enhancing information technology (IT) systems (7 states);
- Developing job aids or tools to assist eligibility staff (4 states);
- Reviewing findings with contractors and staff (4 states); and
- Issuing corrective action plans to the local offices (2 states).

In addition to implementing corrective actions for states reporting in FY 2016, HHS has implemented other corrective actions to assist all states in their review process and error reduction including the following activities:

- Oversight: Conduct joint case review oversight to ensure implementation of the HHS approved state review tools. This new review process was piloted in FY 2016 with a cohort of states that had previously been reviewed in FY 2014 (referred to as Year One states). HHS plans to implement this review process across all reporting states beginning in FY 2017;
- Site Visits: Conduct site visits with states needing assistance to address root causes of errors as resources allow;
- Technical Assistance: Provide technical assistance to states around policy and procedure changes to meet new requirements under the CCDBG. HHS continues to work with states through the Office of Child Care's National Center on Subsidy Innovation and Accountability which was funded to specifically provide technical assistance to states and territories on program integrity and accountability and has been targeting technical assistance to states as it relates to reauthorization;
- Technical Assistance: Deliver technical assistance to states regarding updating or developing IT systems that will improve practices and reduce errors; and
- Methodology Training: Provide individual reporting cohort training on the methodology that allows states to learn best practices from each other as they conduct the improper payment reviews.

### 11.83 CCDF Information Systems and Other Infrastructure

Since CCDF payments occur at the state level, information systems and other infrastructure needed to reduce CCDF improper payments would need to be implemented at the state level. In addition to the efforts outlined in prior HHS AFRs, states reported a range of other improvements to information systems including:

- Increase access to client information: Including data synced with other assistance programs, quality control case reviews or reports, and system flags and blocks to avoid duplication or errors.
- Increase access to provider information: Including automated billing reports, payment management tracking, provider licensing information, and automated payment rate determination.
- Assist with eligibility determinations: Including access to data in other assistance programs' systems to obtain or confirm eligibility information, increased automation of eligibility processes, system flags and blocks to avoid errors, automated copay calculation, and document storage.

Additionally, states also identified IT limitations with preventing or identifying caseworker error when erroneous data is entered.

### 11.84 CCDF Statutory or Regulatory Barriers

No statutory or regulatory barriers that would limit corrective actions have been identified at this time.

The CCDBG, signed into law in November 2014, reauthorized CCDF for the first time since 1996. The statute improves the quality and access to care for children across the country by requiring states to change eligibility to a minimum of 12 months, revise redetermination policies, update provider payment rates and payment practices, and increase health and safety standards for providers. States will be required to create new policies and procedures to enact the requirements of the law, which will likely increase errors as the changes are implemented. The improper payment reduction targets identified in Table 1A reflect the anticipated brief rise in the error rate as states adjust to the changes.

## 12.0 Supplemental Measures and Targets for High-Priority Programs

To comply with Executive Order 13520 and IPERIA, HHS developed supplemental measures for four high-priority programs: Medicare FFS, Medicare Part C, Medicare Part D, and Medicaid. Information on these programs' supplemental measures—including a description of the measure, the current performance, and future performance target—can be found below. In addition, more information on these programs and their supplemental measures can be found at [www.PaymentAccuracy.gov](http://www.PaymentAccuracy.gov).

**Medicare FFS:** A main driver of the Medicare FFS improper payment rate is insufficient documentation errors for home health claims. Some of HHS's corrective actions are discussed in *Section 11.0: Program-Specific Reporting Information*. This annual supplemental measure examines the percentage of improper Medicare FFS payments made for home health claims.

- Current performance: 42.01 percent
- Future performance target: 37.70 percent

**Medicare Part C:** Payments to Medicare Advantage organizations are partly based on enrollee health status. This annual supplemental measure analyzes the CMS Hierarchical Condition Categories (CMS-HCCs) that have the highest rates of error. CMS-HCCs are the disease groups that determine the disease component of risk-adjustment payment. The measure aggregates the CMS-HCCs that have the highest percentage of error as compared to the entire sample of CMS-HCCs, and divides that number of discrepancies by the overall number in the sample.

- Current performance: 4.0 percent
- Future performance target: 4.0 percent

**Medicare Part D:** The Prescription Drug Event (PDE) validation process validates the prescription against the PDE data submitted to HHS for payment and is the major driver of error in Part D. The root cause shown under this annual supplemental measure is missing or illegible supporting documentation.

- Current performance: 1.19 percent
- Future performance target: 1.19 percent

**Medicaid:** State non-compliance with new provider information, enrollment, and screening requirements has been a major driver of Medicaid improper payments in recent years. This annual supplemental measure shows the Medicaid FFS improper payment rate for these errors.

- Current performance: 9.97 percent
- Future performance target: 8.05 percent

## 13.0 Superstorm Sandy Reporting Information

Superstorm Sandy was a major hurricane that struck the United States' eastern seaboard on October 29, 2012 and caused extensive damage from Florida to Maine, with New Jersey and New York sustaining the most damage. In response to this disaster, Congress passed the *Disaster Relief Act*, which was signed into law on January 29, 2013 and provided \$50.5 billion in aid for Superstorm Sandy disaster victims and their communities. HHS received \$747 million, allocated among multiple programs across five Divisions: ACF, ASPR, CDC, SAMHSA, and NIH. Because funding of this type and magnitude often carries additional risk, the *Disaster Relief Act* and OMB guidance state that all federal programs or activities receiving funds are automatically considered susceptible to significant improper payments, regardless of any previous improper payment risk assessment results, and are required to calculate and report an improper payment estimate. Accordingly, HHS developed methodologies to estimate



improper payments in the programs that received *Disaster Relief Act* funding. Once a program's Superstorm Sandy funding has been spent, agencies are no longer required to report error rate information. In FY 2016, HHS halted reporting error rate information for two programs – CDC Research and ACF Family Violence and Prevention Services Act – because they expended their funding. Information on the remaining *Disaster Relief Act* programs' improper payment methodologies, results, and corrective actions can be found on subsequent pages.

### 13.10 Head Start

#### 13.11 Head Start Statistical Sampling Process and Results

Head Start received approximately \$95 million in *Disaster Relief Act* funding to provide services, training and oversight, and construction assistance to affected grantees. Every grantee who spends Superstorm Sandy funds receives an erroneous payments onsite monitoring visit in the quarter following the quarter when funds are spent, or as soon thereafter as possible. Superstorm Sandy transactions for each quarter are reviewed using a standard onsite monitoring tool to identify potential and actual erroneous payments. Additional information on Head Start's statistical sampling process can be found on pages 223 – 224 of HHS's FY 2015 AFR, available at: [www.hhs.gov/afr](http://www.hhs.gov/afr).

Nearly all minor renovations and repairs to facilities, along with remaining enhanced mental health service activities, were completed in FY 2015. In FY 2016, grantees were primarily engaged in ongoing progress toward completion of major renovations and reconstruction of damaged facilities with HHS subject matter experts and regional staff working closely with grantees on a day-to-day basis. This resulted in fewer transactions in FY 2016, but larger total expenditures than in FY 2015.

The Head Start gross and net improper payment estimate for FY 2016 is 0 percent or \$0.

#### 13.12 Head Start Root Causes and CAP

##### Corrective Actions to Address Root Cause

No improper payments were identified for the review period. However, HHS continues to work with grantees to reduce the likelihood of the occurrence of improper payments by staying in regular communication with grantees to support ongoing compliance in areas such as procurement standards, source documentation, Davis-Bacon Act, cost allocation plan updates, and any other areas identified by subject matter experts as common areas of fiscal challenge in the general grantee community.

#### 13.13 Head Start Improper Payment Recovery

No improper payments were identified during the period under review (PUR) and all prior year errors subject to recovery were recovered during the PUR in which they were identified.

### 13.20 SSBG

#### 13.21 SSBG Statistical Sampling Process and Results

The SSBG program received \$474.5 million in *Disaster Relief Act* funding to address necessary expenses resulting from Superstorm Sandy. These expenses include social, health, and mental health services for individuals; and repair, renovation and rebuilding of health care facilities (including mental health facilities), child care facilities, and other social services facilities. The SSBG *Disaster Relief Act* funds were allocated to five states affected by Superstorm Sandy: Connecticut, Maryland, New Jersey, New York, and Rhode Island. HHS selected 3 of the 5

states (Connecticut, New Jersey, and New York) to calculate improper payment error rates, since their allocations represent 99 percent of all SSBG *Disaster Relief Act* funds.

Because the states determine the types of services and eligibility for these services, as permitted by the SSBG law and regulations, there is considerable variation among states in their application of these funds. To account for this variation, HHS developed a two-fold (bifurcated) improper payment methodology to review the use of SSBG *Disaster Relief Act* funds in three states. The two methodologies are a case record review and a vendor payment review. The case record review examines payments or benefits provided to or on behalf of individuals, families or households (i.e., cases) based on specific eligibility criteria. The vendor payment review examines individual payments made to service vendors and assesses if the vendors provided adequate documentation (e.g., applications or authorizations) necessary to meet the eligibility requirements for these payments.

For the FY 2016 review period (July 1, 2015 to June 30, 2016), HHS completed case record and vendor payment reviews in Connecticut, New Jersey, and New York. HHS consolidated its review findings and calculated a national SSBG Superstorm Sandy *Disaster Relief Act* error rate from the aggregate findings across all three states.

HHS reviewed 612 records in FY 2016. For the case record review, HHS reviewed 312 case records across the 3 states – 47 cases in Connecticut, 181 cases in New Jersey, and 84 cases in New York. For the vendor payment review, HHS reviewed 300 vendor payments across the three states – 5 payments in Connecticut, 111 payments in New Jersey, and 184 payments in New York.

The SSBG gross and net improper payment estimate for FY 2016 is 0.68 percent or \$1.35 million.

The error rate for the case record reviews was 1.84 percent, while the error rate for the vendor payment reviews was 0.55 percent.

### 13.22 SSBG Root Causes and CAP

Of the 612 records reviewed, 37 records had an improper payment.

Three errors (representing 0.002 percent of the estimated improper payments) were categorized as administrative or process errors due to state or local agency. These errors included: (1) miscalculation of payment amounts due to an incorrect formula; and (2) clerical errors in calculating payment amounts based on vendor claims.

Twenty-one errors (representing 20.74 percent of the estimated improper payments) were categorized as administrative or process errors due to other party (i.e., non-federal, non-state, and non-local agencies). These errors included: (1) clients receiving greater than necessary benefit amounts; (2) service provider mistakenly disposing of client eligibility documentation (though the provider was able to obtain new documentation after reviews were completed); (3) clients receiving benefits despite documentation indicating ineligibility for service; (4) clients receiving benefits despite not fully completing eligibility documentation; (5) clients receiving benefits before fully establishing their eligibility for service; (6) a service provider failing to obtain client's signature verifying receipt of benefits; and (7) a service provider issuing a benefit payment on a client's behalf before all internal payment approval processes were completed.

Thirteen errors (representing 79.26 percent of the estimated improper payments) were categorized as insufficient documentation to determine. These errors included: (1) case records missing necessary eligibility documentation (e.g., proof of insurance or proof of income); or (2) records missing necessary documentation of proper payment processing (e.g., proof of payment, payment approval forms, or copies of bills/invoices to be paid).

### Corrective Actions to Address Root Causes:

In response to FY 2016 improper payment findings, HHS will provide each reviewed state a letter outlining the development of CAPs. These letters will be accompanied by itemized lists of unresolved errors from the FY 2016 review period (including descriptions of improper payment findings and amounts), and will establish a 30-day timeframe for states to respond with planned corrective actions. HHS will also hold calls with each state to answer any questions related to developing CAPs or establishing improper payment recovery amounts. In developing their responses, states may provide an explanation for recovery amounts to be sought for each error; however, HHS retains final discretion in determining total amounts of funds subject to recovery. Further information on specific root causes and corrective actions is located below.

#### ***Root Cause: Administrative or Process Errors Made by State or Local Agency***

To address these errors, HHS will develop strategies with states to ensure that all documentation required for payment processing is present and complete before payments to vendors are approved. These activities will also emphasize examination of receipts and invoices to ensure that payments made by the states reflect established payment schedules and reimbursement protocols. HHS will continue to work with states to examine where in their payment approval processes the greatest intervention is warranted.

#### ***Root Cause: Administrative or Process Errors Made by Other Party***

To address these errors, HHS will develop strategies with states to reinforce the importance of: (1) collecting all client eligibility documentation prior to the provision of service benefits; (2) ensuring that eligibility documentation is properly examined; (3) providing benefits to clients that match their documented needs; (4) preserving critical case record documentation for auditing needs; and (5) ensuring that payment processing procedures are followed, such that payments/benefits are not dispersed until all requisite signatures/approvals are obtained. HHS will continue to work with states to address how error-prone vendors can improve their client intake processes and improve processes for assessing and approving client benefits.

#### ***Root Cause: Insufficient Documentation to Determine***

To address these errors, HHS will develop strategies with states to monitor and provide oversight to the most error-prone service agencies and providers. These strategies will reinforce the importance of record maintenance and organization. HHS will work with states to assess typical practices of record maintenance and organization.

### 13.23 SSBG Improper Payment Recovery

Of the total error findings, \$1.35 million was associated with overpayments. As states receive and review all unresolved errors from the FY 2016 review period, HHS will work with states to identify items for which additional corrective action will be taken (including obtaining additional documentation, making process adjustments, and the current state of improper payment recovery). Where additional action around improper payment recovery is warranted, HHS will work with states to focus recovery efforts on improper payments resulting from core eligibility errors, where benefits or payments should not have been paid. HHS is also working with states to recover overpayments identified in previous measurement cycles, as appropriate.

### 13.30 ASPR Research

#### 13.31 ASPR Research Statistical Sampling Process and Results

ASPR received approximately \$11.9 million in *Disaster Relief Act* funding to evaluate preparedness and response activities in the affected states. ASPR's Superstorm Sandy improper payment methodology was conducted in two stages. Under the first stage, for FY 2014 reporting, HHS reviewed the eligibility of grantees that received funding in FY 2013. The second stage of the methodology was implemented in FY 2015 and continued in FY 2016. The

methodology calculates an unallowable spending error rate (e.g., unallowable expenses or lack of documentation) based on a review of each grantee's expenditures during the review period. The sample for the FY 2016 reporting period consisted of expenditures made during FY 2015 (October 1, 2014 to September 30, 2015).

Based on a review of over 900 transactions, the ASPR Research gross and net improper payment estimate for FY 2016 is 0 percent or \$0.

### 13.32 ASPR Research Root Causes and CAP

#### Corrective Actions to Address Root Cause:

Although HHS has not identified any improper payments in the ASPR Research program in FY 2016, HHS established internal controls to prevent improper payments from occurring.

### 13.33 ASPR Research Improper Payment Recovery

No recoveries will be attempted as no improper payments were identified during this or previous reviews.

### 13.40 SAMHSA

#### 13.41 SAMHSA Statistical Sampling Process and Results

SAMHSA received \$10 million under the *Disaster Relief Act*. SAMHSA awarded approximately \$6.2 million to four programs and returned approximately \$3.8 million because fewer organizations applied for the funding and applications received were for amounts significantly less than expected. The four funded programs were: 1) Behavioral Health Treatment; 2) Disaster Distress Helpline; 3) Resiliency Training for Educators; and 4) Medication Assisted Treatment of Opioid Addiction Restoration.

For FY 2016, SAMHSA's program universe subject to sampling consisted of four grants awarded to New York State (\$798,339), New York City (\$2,947,786), New Jersey (\$329,120), and Links2Health (\$2,100,000) for the four funded programs listed above. Between July 1, 2015 and June 30, 2016, SAMHSA had outlays of \$1.279 million across 13 transactions. Due to the small number of transactions, SAMHSA reviewed all outlays for payment accuracy and used the results to calculate the total improper payments for the program.

SAMHSA's gross improper payments for FY 2016 is 0.05 percent or \$624.59; the net improper payments estimate is 0.05 percent or \$624.59.

#### 13.42 SAMHSA Root Causes and CAP

SAMHSA's improper payments identified during the review period were due to administrative or process errors made by the grantees (100 percent). The total gross improper payments of \$624.59 were due to one transaction that improperly calculated direct and indirect expenses.

#### Corrective Actions to Address Root Cause:

##### **Root Cause: Administrative or Process Errors Made by Other Party**

SAMHSA's improper payment results were discussed with the grantee; to date, the grantee has not indicated concurrence with the findings. SAMHSA does not anticipate future improper payments, as the grants under the specified programs have ended.

### 13.43 SAMHSA Improper Payment Recovery

SAMHSA is correcting the entire \$624.59 in improper payments by requesting a refund from the grantee.

### 13.50 NIH Research

#### 13.51 NIH Research Statistical Sampling Process and Results

NIH received \$148.7 million in funds under the *Disaster Relief Act* to support recovery efforts at eligible impacted universities and research institutions. These funds will restore NIH's investment in biomedical research and infrastructure that was severely damaged or destroyed by Superstorm Sandy.

Due to the variable grant expenditure amounts, NIH implemented a stratified random sampling process, with the sampling frame being divided into mutually exclusive groups or "strata" based on expenditure amount. Each sampling period consisted of six months. NIH selected a random sample of expenditures from the grantees quarterly reports for the respective two quarters. The sampling unit was the total quarterly expenditures for a single award, while the sampling frame was the collection of all reports filed containing expenditures during the sampling period. NIH used a random number generator to assign random numbers to each quarterly expenditure report. The list of expenditure reports was sorted by stratum and random number, and the appropriate number of items from each stratum was reviewed. NIH's methodology examined two areas for improper payments: (1) ensuring funds were used for an allowable program use and (2) grantee eligibility. For each grant in the sample, NIH requested detailed expenditure data and appropriate backup documentation from the grantee to determine allowability of expenditures. NIH also confirmed grantees' continued eligibility to receive *Disaster Relief Act* funding in accordance with HHS requirements.

Under its methodology, NIH completed two rounds of improper payment reviews from FY 2014 to FY 2016 covering 12-months of expenditures in two semi-annual sampling periods: July 1 to December 31 and January 1 to June 30. For FY 2015, NIH reviewed 357 expenditure reports representing 242 grant awards and 18 different grantee institutions. For FY 2016, NIH reviewed 71 expenditure reports representing 50 grant awards and 14 different grantee institutions. The sample was smaller in FY 2016 due to the end of the two-year funding period.

The NIH Research gross and net improper payment estimate for FY 2016 is 0 percent or \$0.

#### 13.52 NIH Research Root Causes and CAP

HHS did not identify any improper payments in the NIH Research program in FY 2016.

#### 13.53 NIH Research Improper Payment Recovery

No recoveries will be attempted as no improper payments were identified.

## 14.0 Internal Control Over Payments

In FY 2016, the Department summarized HHS's status of internal control over payments for each program reporting an improper payment rate, as required by Appendix C to OMB Circular A-123. HHS's error rate measurements and root cause analyses have led to the implementation of a number of effective strategies to prevent, detect, and recover improper payments (many of which are discussed in *Section 11.0: Program-Specific Reporting Information*) and help create and maintain a robust internal control system. Generally, these strategies

are tailored to the nature of program improper payments resulting from administrative and documentation errors rather than from fraud and abuse. Examples of HHS's internal control over payment efforts include:

- Implementing key control activities to prevent and detect improper payments;
- Using, sharing, and communicating information that is timely, accurate, and reliable; and
- Performing monitoring and assessment activities.

Additional information on internal control over payment efforts can be found on pages 208 – 216 of the FY 2015 AFR, available at: [www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf](http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf). As shown in Table 3 below, HHS programs have implemented internal controls to prevent improper payments. HHS continues to improve and evaluate its internal control over payment efforts.

**Table 3**  
**FY 2016 Risk Susceptible Programs Status of Internal Controls**

Internal Control Standards	Medicare FFS	Medicare Part C	Medicare Part D	Medicaid	CHIP	Foster Care	Child Care
Control Environment	4	4	4	3	3	3	3
Risk Assessment	4	4	4	4	4	4	3
Control Activities	3	3	3	3	3	4	3
Information and Communication	4	4	4	3	3	3	3
Monitoring	3	3	3	3	3	4	3

**Legend:**

- 4 = Sufficient controls are in place to prevent improper payments.
- 3= Controls are in place to prevent improper payments but there is room for improvement.
- 2 = Minimal controls are in place to prevent improper payments.
- 1= Controls are not in place to prevent improper payments.

## 15.0 Recovery Auditing Reporting

HHS developed a risk-based strategy to implement the recovery auditing provisions of IPERA. Specifically, HHS focuses on implementing recovery audit programs in Medicare and Medicaid, which accounted for 86 percent of HHS's outlays in FY 2016. HHS is progressing in recovering improper payments in Medicare and Medicaid and, most importantly, implementing corrective actions to prevent improper payments, as described below.

### **Medicare FFS RACs**

Section 302 of the *Tax Relief and Health Care Act of 2006* required HHS to implement the Medicare FFS RAC program in all 50 states no later than January 1, 2010. HHS allows the RACs to review a variety of claim types, except for hospital patient status reviews, which are limited to only those providers referred by the QIOs for exhibiting persistent noncompliance with Medicare payment policies. HHS has been working to procure the next RAC contracts since 2013. However, multiple pre- and post-award protests have delayed the awards. As HHS continued the procurement process for the new contracts, the current contracts have been modified to allow the RACs to review claims through July 31, 2016, after which the RACs have continued to work to resolve all open claims and claims adjustments. As part of these contract modifications, HHS incorporated several program enhancements developed in response to industry feedback:

- Reducing the complex review timeframe from 60 to 30 days and withholding the contingency fee if the RAC does not meet its review deadline;

- Requiring the RAC to wait 30 days to allow for a discussion with the provider after identifying an improper payment before sending the claim to the MAC for adjustment;
- Confirming receipt of a discussion request and other written correspondence within three days;
- Broadening review topics to all provider types and requiring reviews of topics referred by HHS; and
- Enhancing the information available on the provider web portals.

In addition, HHS established requirements known as Additional Documentation Request (ADR) limits on the number of claims that RACs can review for each provider. In FY 2016, HHS revised its ADR limits for institutional providers to be diversified across the different claim types a facility submits (e.g., inpatient and outpatient claims). HHS will adjust the limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits. RACs are also required to apply incrementally the ADR limits for providers new to RAC reviews. HHS expects to award the new RAC contracts in early FY 2017.

In FY 2016, the Medicare FFS RAC program identified approximately \$440.53 million in overpayments and recovered \$404.46 million. Policy changes regarding the payment and treatment of inpatient hospital claims and a delay in awarding new Medicare FFS RAC contracts resulted in fewer reviews in FY 2016 compared to previous years. Meanwhile, amounts that HHS identified in previous years continue to be collected. During FY 2016, the majority of Medicare FFS RAC collections were from Diagnosis Related Group validations and outpatient therapy reviews.

In addition to using the Medicare FFS RACs to identify overpayments, HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, in FY 2016, HHS released quarterly Provider Compliance Newsletters that offered detailed information on 12 findings identified by the Medicare FFS RACs. Also, HHS used these findings to implement local and/or national system edits to prevent improper payments. More information on the Medicare FFS RAC program can be found at: [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program).

#### ***Medicare Secondary Payer RACs***

The Medicare Secondary Payer (MSP) RAC began full recovery operations at the end of FY 2013 and operates as the MSP Commercial Repayment Center (CRC). The CRC reviews information collected by HHS regarding beneficiaries that had or have primary coverage through an employer-sponsored Group Health Plan (GHP) and, as of FY 2016, situations where a Non-Group Health Plan (NGHP), such as a Workers' Compensation entity or No-Fault insurer, has or had primary payment responsibility. When GHP information is incomplete, Medicare FFS may mistakenly pay for services as the primary payer. The CRC recovers these mistaken payments from the entity that had primary payment responsibility (typically the employer or other plan sponsor, insurer, or claims processing administrator). The debtors for these GHP MSP debts do not have formal appeal rights, but do have the opportunity to dispute the debt through the established "defense" process. In FY 2016, the CRC workload expanded to include the recovery of certain conditional payments made by Medicare FFS until HHS identifies an NGHP with primary payment responsibility. Upon learning that the NGHP has primary payment responsibility, the CRC initiates recovery of these conditional payments.

In FY 2016, the CRC identified approximately \$243.68 million and collected \$106.29 million in mistaken payments. Collections decreased by about \$43.31 million in FY 2016, compared to \$149.60 in FY 2015. FY 2015 collections were higher due to a one-time surplus of available GHP recoveries during that year. More information on the CRC can be found at: [www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Group-Health-Plan-Recovery/Group-Health-Plan-Recovery.html](http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Group-Health-Plan-Recovery/Group-Health-Plan-Recovery.html).

**Medicare Part C and Part D RACs**

Section 6411(b) of the *Affordable Care Act* expanded the RAC program to Medicare Parts C and D. As part of the procurement process to secure a Medicare Part C RAC, HHS posted a Request for Quote in June 2014; however, HHS did not receive any responses to the solicitation. More recently, HHS posted a Request for Information in December 2015 to solicit additional feedback from industry regarding this program, and received several submissions in response to the announcement. HHS continues its implementation efforts and anticipates awarding a Part C RAC contract in 2017.

The Part D RAC program became fully operational in FY 2012. Since its launch, the Part D RAC recouped overpayments made as a result of prescriptions written by excluded or unauthorized providers and improper refills of Drug Enforcement Agency scheduled drugs. The Part D RAC recouped approximately \$2.30 million in FY 2016. In addition, notifications of improper payments were sent to plan sponsors in FY 2016, totaling approximately \$7.95 million and recoupments are expected to occur in FY 2017.

More information on the Medicare Part C and Part D RAC programs can be found at: [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/index.html).

**State Medicaid RACs**

Section 6411(a) of the *Affordable Care Act* required states to submit assurances by December 31, 2010 that their programs meet the statutory requirements to establish State Medicaid RAC programs. States were required to implement RAC programs by January 1, 2012. Thus, FY 2016 is the fourth full federal FY of reporting State Medicaid RAC recoveries. As states continue to implement their State Medicaid RAC programs, State Medicaid RAC federal-share recoveries totaled \$44.31 million in FY 2016. State Medicaid RAC federal-share recoveries include overpayments collected, adjusted, or refunded to HHS, as reported by states on the CMS-64.

By the end of FY 2016, 47 States and the District of Columbia had implemented Medicaid RAC programs to identify and recover overpayments and identify underpayments in their Medicaid programs. However, each state has the flexibility to tailor its RAC program where appropriate with guidance from HHS. For example, two of the states that have implemented Medicaid RAC programs ended their RAC programs when HHS approved an exception due to the high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS. Five states currently have time-limited HHS-approved exceptions to Medicaid RAC implementation due to high managed care penetration or small beneficiary populations.

**Recovery Auditing Reporting Tables**

OMB Circular A-136 requires agencies to provide detailed information on their recovery auditing programs, as well as other efforts related to the recapture of improper payments. Some of our programs have results to report in this area and those results are included in the following tables. If HHS excluded a program from a table, it is because it does not have results in that area.



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**Table 4**  
**Overpayments Recaptured with and without Recapture Audit Programs**  
FY 2016 (in Millions)

Program or Activity	Payment Recapture Audits of Contracts					Payment Recapture Audits of Benefits					Total		Overpayments Recaptured Outside of Payment Recapture Audits	
	Amount Identified	Amount Recaptured Note (1)	CY Recapture Rate	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured Note (1)	CY Recapture Rate	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured	Amount Identified	Amount Recaptured
Medicare FFS Error Rate Measurement Note (2)													\$25.55	\$22.02
Medicare FFS Recovery Auditors	\$440.53	\$404.46	91.81%	85.00%	85.00%						\$440.53	\$404.46		
Medicare Secondary Payer Recovery Auditor	\$243.68	\$106.29	43.62%	85.00%	85.00%						\$243.68	\$106.29		
Medicare Contractors Note (3)													\$14,534.26	\$12,267.70
Medicare Part C Note (4)													\$316.88	\$316.88
Medicare Part C Recovery Auditors Note (5)														
Medicare Part D Note (4)													\$9.53	\$9.53
Medicare Part D Recovery Auditors	\$7.95	\$2.30	28.93%	85.00%	85.00%						\$7.95	\$2.30		
Medicare C RADV Audits Note (6)														
Medicaid Error Rate Measurement Note (7)													\$4.08	\$0.70
CHIP Error Rate Measurement Note (7)													\$1.63	\$0.26
Medicaid Integrity Contractors-Federal Share Note (8)													\$33.64	\$9.02
State Medicaid Recovery Auditors - Federal Share Note (9)						N/A	\$44.31	N/A	N/A	N/A	N/A	\$44.31		
Foster Care Eligibility Reviews-Post Payment Reviews													\$1.43	\$1.43 (Note 10)

**Table 4**  
**Overpayments Recaptured with and without Recapture Audit Programs**  
 FY 2016 (in Millions)

	Payment Recapture Audits of Contracts					Payment Recapture Audits of Benefits					Total		Overpayments Recaptured Outside of Payment Recapture Audits	
Program or Activity	Amount Identified	Amount Recaptured Note (1)	CY Recapture Rate	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured Note (1)	CY Recapture Rate	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured	Amount Identified	Amount Recaptured
Foster Care OIG Reviews													\$0.00	\$65.52
Foster Care Single Audits													\$2.27	\$7.91
Child Care Single Audits													\$25.43	\$0.13
Child Care Error Rate Measurement Note (11)													\$0.11	\$0.02
Child Care OIG Reviews													\$3.02	\$7.38
Head Start OIG Reviews													\$0.63	\$0.15
Head Start Single Audits													\$4.49	\$2.22
ACF OIG Reviews - All Other Programs													\$8.19	\$25.53
ACF Single Audits - All Other Programs													\$1.44	\$2.12
Superstorm Sandy SSBG Error Rate Measurement Note (12)													\$0.12	\$0.00
Superstorm Sandy SAMHSA Error Rate Measurement													\$0.0006	\$0.00
<b>TOTAL</b>	\$692.16	\$513.05	74.12%	85.00%	85.00%		\$44.31				\$692.16	\$557.36	\$14,972.70	\$12,738.52

## Notes:

1. The amount reported in the Amount Recaptured column is the amount recovered in FY 2016, regardless of the year HHS identified the overpayment.
2. The actual overpayments identified by the CERT program during the FY 2016 report period were \$25,552,562.45. The identified overpayments are recovered by the MACs via standard payment recovery methods. As of the report publication date, MACs reported collecting \$22,015,289.85 or 86.16 percent of the actual overpayment dollars.
3. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS Recovery Auditors program and the Medicare FFS Error Rate Measurement program, which HHS reports separately in this table.
4. The values in the Medicare Part C and Medicare Part D rows represent overpayments reported and returned by Medicare Advantage organizations and Part D sponsors, respectively.
5. HHS expects to award a contract for a Medicare Part C RAC program in 2017.
6. During FY 2016, HHS continued the contract-level RADV audits based on calendar years 2011 and 2012 and

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launched the calendar year 2013 audits. As such, there were no RADV payment amounts identified or recovered in FY 2016.

7. For the Medicaid and CHIP Error Measurement rows, HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed. Recoveries of Medicaid and CHIP improper payments are governed by the *Social Security Act* and related regulations under which states must return the federal share of overpayments. States reimburse HHS for the federal share of overpayments. Section 6506 of the *Affordable Care Act* amended the *Social Security Act* to allow states up to one year from the date of discovery of an overpayment for Medicaid and CHIP services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment.
8. For Medicaid, the Medicaid Integrity Contractors identified total overpayments that include both the federal and state shares. However, HHS reports only the actual federal share across audits.
9. For the State Medicaid Recovery Auditor row, states are only required to report the amount of recoveries on the CMS-64, and not the amount of improper payments identified or recovery rates or targets. The State Medicaid Recovery Auditors Amount Recaptured cell represents the federal share of the state recoveries as of the publication date of the AFR.
10. As a result of conducting Foster Care eligibility reviews in 16 states during the 12-month period between July 2015 and June 2016, HHS recovered over \$1.4 million in Title IV-E improper payments. The recovered funds are comprised of \$1,043,326 in disallowed maintenance payments and \$382,688 in disallowed administrative payments.
11. The Child Care Error Rate Measurement information reflects overpayments that are identified through the statistical sampling process. The information reported represents the amount that is subject to disallowance. For the Child Care Error Rate Measurement Amount Recaptured information, states are required to recover child care payments that are the result of fraud and have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error. Data reported in FY 2016 represent improper payments recovered by the Year Three states based on improper payments identified in FY 2013.
12. In FY 2016, HHS formally requested grantees to determine whether selected overpayments would be recaptured and allocated towards an allowable activity or repaid to the federal government. Grantees plan to complete actions for recapture or repayment in FY 2017.

**Table 5**  
**Disposition of Funds Recaptured Through Payment Recapture Audit Programs**  
FY 2016 (in Millions)

Program or Activity	Amount Recaptured	Type of Payment	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose Note (1)	Office of Inspector General	Returned to Treasury
Medicare FFS Recovery Auditors	\$404.46	Contract	\$20.82	\$39.12	N/A	\$275.06	N/A	N/A
Medicare Secondary Payer Recovery Auditor	\$106.29	Contract	\$0.53	\$17.41	N/A	\$88.35	N/A	N/A
Medicare Part D Recovery Auditors	\$2.30	Contract	N/A	\$0.46	N/A	\$1.84	N/A	N/A
State Medicaid Recovery Auditors – Federal Share Note (2)	\$44.31	Benefits	N/A	N/A	N/A	N/A	N/A	\$44.31
<b>Total</b>	<b>\$557.36</b>		<b>\$21.35</b>	<b>\$56.99</b>	<b>N/A</b>	<b>\$365.25</b>	<b>N/A</b>	<b>\$44.31</b>

## Notes:

1. Funds included under the Original Purpose column were returned to the Medicare Trust Funds after taking into consideration agency expenses to administer the program and recovery auditor contingency fees. In addition, the Medicare FFS Recovery Auditors Original Purpose cell also takes into consideration underpayments to providers that were identified and corrected (\$69.46 million).
2. The state Medicaid recovery auditors' row only includes information on the federal share of recoveries, which are returned to Treasury. States do not report information to HHS on how the state portions of recoveries are used.

**Table 6**  
**Aging of Outstanding Overpayments Identified in the Payment Recapture Audit Programs**  
 FY 2016 (in Millions)<sup>Note (1)</sup>

Program or Activity	Type of Payment	CY Amount Outstanding (0 – 6 months)	CY Amount Outstanding (6 months to 1 year)	CY Amount Outstanding (over 1 year)	Amount Determined to Not be Collectable
Medicare FFS Recovery Auditors	Contract	\$45.51 Note (2)	\$44.20	\$1,598.15	N/A
Medicare Secondary Payer Recovery Auditor Notes (3) and (4)	Contract	\$155.53	\$24.36	\$0.00	N/A
Medicare Part D Recovery Auditors	Contract	N/A Note (5)	N/A	N/A	N/A
Total		\$201.04	\$68.56	\$1,598.15	N/A

## Notes:

1. The state Medicaid recovery auditors are not included in this table since states do not report information to HHS that would allow the Department to calculate the aging of overpayment amounts that are currently outstanding.
2. Under the Medicare FFS recovery auditors program, recovery of identified overpayments cannot begin until the overpayment is at least 41 days old. Therefore, the CY Amount Outstanding (0-6 months) includes identified overpayments that HHS cannot begin collecting.
3. The Medicare Secondary Payer recovery auditor maintains debts established under prior MSP recovery programs; consequently, collections exclusively related to mistaken payments identified by the MSP recovery auditor does not directly correlate to the amount outstanding.
4. The amount of outstanding payments identified by the Medicare Secondary Provider recovery auditor included in this table reflect the outstanding balances on debts identified in FY 2016.
5. Recoupments of FY 2016 Part D overpayments will not begin until the appeals process is complete. The appeals process is ongoing, but is expected to be completed during FY 2017. However, as stated in *Section 15.0*, HHS recovered \$2.30 million in overpayments that the Part D RAC identified in previous years.

## 16.0 Do Not Pay Initiative

In June 2010, the President issued a Memorandum on Enhancing Payment Accuracy Through a "Do Not Pay List" in a network of databases where agencies can access relevant information before determining eligibility for a benefit, grant or contract award, or other federal funding. Subsequently, the "Do Not Pay List" was codified by IPERIA. The Presidential memorandum and IPERIA identified six databases to include in the Do Not Pay (DNP) portal. Treasury's DNP website – [www.donotpay.treas.gov/index.htm](http://www.donotpay.treas.gov/index.htm) - includes information on currently available and pending data sources in the DNP portal.

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Since 2010, HHS has worked diligently to implement the DNP initiative. HHS and CMS established a Computer Matching Agreement (CMA) with Treasury under the DNP initiative in FY 2014. HHS has continued to receive information through the CMA that was established in FY 2014 and worked to establish additional CMAs in FY 2016. In addition, several of our Divisions are continuing to use DNP to check for recipients' or potential recipients' eligibility and to prevent improper payments. Treasury-disbursed payments are matched against the SSA's DMF and the General Services Administrations' excluded parties' elements of the System for Award Management in the DNP portal to identify improper payments on a daily basis. While the Department identified four potential improper payments over the past year as part of these daily matches (as shown in Table 8), there were no confirmed matches in FY 2016. Lastly, CMS is also checking certain payments against IPERIA-listed databases outside of the DNP portal, and reporting results for the first time in FY 2016. The results of these matches can also be found in Table 7.

**Table 7**  
**Results of the Do Not Pay Initiative in Preventing Improper Payments**  
FY 2016

	Number (#) of payments reviewed for possible improper payments	Dollars (\$) of payments reviewed for possible improper payments	Number (#) of payments stopped	Dollars (\$) of payments stopped	Number (#) of potential improper payments reviewed and determined accurate	Dollars (\$) of potential improper payments reviewed and determined accurate.
Reviews with the IPERIA specified databases disbursed by Treasury Note (1)	1,230,677 Note (2)	\$385,481,524,698.27	0 Note (3)	0 Note (3)	4 Note (4)	\$488.90 Note (4)
Reviews with the IPERIA specified database disbursed by CMS Note (5)	1,139,204,538	\$395,065,205,838.23	656,399 Note (3)	\$1,576,586,430.05 Note (3)	N/A Note (6)	N/A Note (6)
Reviews with databases not listed in IPERIA	N/A	N/A	N/A	N/A	N/A	N/A

## Notes:

1. This row shows payments that are disbursed through Treasury and matched against IPERIA specified databases.
2. HHS data included 18,857 payment records that contained missing or invalid information.
3. "Payments Stopped" refers to payments for which the agency has implemented Stop Payment Rules or a similar method of disbursement prevention during the pre-payment stage. It does not include post-payment reclamations, collections, or offsets.
4. This cell includes information on payments that were flagged as potentially improper, but were determined proper after further review.
5. This row represents the Medicare FFS payments that were reviewed for improper payments. Medicare FFS payments are not disbursed by Treasury but are also matched against databases listed in IPERIA.
6. Data on payments that were flagged as potentially improper, but were determined proper after further review, is not included in the table. However, 134,073 payments totaling \$67,724,395.65 for deceased beneficiary's claims were not stopped and subsequently determined improper after further review.

## SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

As described in the “Management’s Discussion and Analysis” section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to the material weakness identified during the audit, as well as conformance with FMFIA and compliance with FFMIA.

**Table 1: Summary of Financial Statement Audit**

Audit Opinion			Unmodified for Four Financial Statements. No Opinion Expressed on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			No		
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
Financial Reporting, Systems, Analyses & Oversight	–	–	–	–	–
NIH Financial Management Systems and Review Processes	–	–	–	–	–
Financial Information Systems	1	–	–	–	1
<b>Total Material Weaknesses</b>	<b>1</b>	–	–	–	<b>1</b>

### Definition of Terms – Tables 1 and 2

(Reference: OMB Circular A-136, *Financial Reporting Requirements*, October 7, 2016, page 143)

**Beginning Balance:** The beginning balance will agree with the ending balance of material weaknesses from the prior year.

**New:** The total number of material weaknesses that have been identified during the current year.

**Resolved:** The total number of material weaknesses that have dropped below the level of materiality in the current year.

**Consolidated:** The combining of two or more findings.

**Reassessed:** The removal of any finding not attributable to corrective actions (e.g., management has re-evaluated and determined a finding does not meet the criteria for materiality or is redefined as more correctly classified under another heading (e.g., Section 2 to a Section 4 and vice versa).

**Ending Balance:** The agency’s year-end balance of material weaknesses.

Table 2: Summary of Management Assurances

Effectiveness of Internal Control over Financial Reporting (FMFIA #2)						
Statement of Assurance	Modified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Information System Controls and Security	1	-	-	-	1 <sup>29</sup>	0
<b>Total Material Weaknesses</b>	<b>1</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1</b>	<b>0</b>

Effectiveness of Internal Control over Operations (FMFIA #2)						
Statement of Assurance	Modified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Information System Controls and Security	1	-	-	-	-	1
Error Rate Measurement	1	-	-	-	-	1
Medicare Appeals Process	0	1	-	-	-	1
<b>Total Material Weaknesses</b>	<b>2</b>	<b>1</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3</b>

Conformance with Federal Financial Management System Requirements (FMFIA #4)						
Statement of Assurance	Federal Systems conform to financial management system requirements					
Non-Conformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Information System Controls and Security	1	-	-	-	1 <sup>29</sup>	0
<b>Total Non-Conformances</b>	<b>1</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1</b>	<b>0</b>

Compliance with Section 803(a) of the <i>Federal Financial Management Improvement Act</i> (FFMIA)		
	Agency	Auditor
<b>1. Federal Financial Management System Requirements</b>	No lack of compliance noted	Lack of compliance noted
<b>2. Applicable Federal Accounting Standards</b>	No lack of compliance noted	No lack of compliance noted
<b>3. USSGL at Transaction Level</b>	No lack of compliance noted	No lack of compliance noted

<sup>29</sup> With the revision of OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, HHS reassessed the Information System Controls and Security material weakness and determined that the factors contributing to the material weakness are more correctly classified under the heading Effectiveness of Internal Control over Operations (FMFIA #2). The auditor categorized the same FMFIA material weakness as a lack of compliance with FFMIA (FMFIA #4).

## FY 2016 TOP MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY THE OFFICE OF INSPECTOR GENERAL



DEPARTMENT OF HEALTH AND HUMAN SERVICES

### OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



**TO:** The Secretary

**FROM:** Daniel R. Levinson, Inspector General *Daniel R. Levinson*

**DATE:** November 7, 2016

**SUBJECT:** Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2016

This memorandum transmits the Office of Inspector General's (OIG) list of top management and performance challenges facing the Department of Health and Human Services (Department). The Reports Consolidation Act of 2000, Public Law 106-531, requires OIG to identify these management challenges, assess the Department's progress in addressing each challenge, and submit this statement to the Department annually.

OIG's top management and performance challenges for fiscal year 2016 are:

1. Ensuring Program Integrity in Medicare Parts A and B
2. Effectively Administering the Medicaid Program to Improve Oversight of Managed Care, Address High Improper Payments, and Strengthen Program Integrity
3. Health Information Technology and the Meaningful and Secure Exchange and Use of Electronic Information
4. Improving Financial and Administrative Management
5. Ensuring the Proper Administration of HHS Grants for Public Health and Human Services Programs
6. Curbing the Abuse and Misuse of Controlled and Non-controlled Drugs in Medicare Part D and Medicaid
7. Ensuring Quality of Care and Safety for Vulnerable Populations
8. Operating and Overseeing the Health Insurance Marketplaces
9. Managing Delivery System Reform and Strengthening Medicare Advantage
10. Ensuring the Safety of Food, Drugs, and Medical Devices

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the beneficiaries of these programs. If you have any questions or comments, please contact me, or your staff may contact Christopher Seagle, Director of External Affairs, at (202) 260-7006 or [Christopher.Seagle@oig.hhs.gov](mailto:Christopher.Seagle@oig.hhs.gov).



## Top Management and Performance Challenges Facing the Department

The Office of Inspector General (OIG) has identified 10 top management and performance challenges facing the Department of Health and Human Services (HHS) as it strives to fulfill its mission “to enhance the health and well-being of Americans by providing effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.” These top challenges arise across HHS programs, including, Medicare, Medicaid, the Public Health Service, and the Indian Health Service. These challenges cover critical HHS responsibilities that include delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity. OIG maintains a list of recommended solutions to address vulnerabilities detected in its audits and evaluations and identifies the top unimplemented recommendations that, if implemented, are likely to garner significant savings and improvements in efficiency and effectiveness. Unimplemented recommendations may be found on our website at <https://oig.hhs.gov/reports-and-publications/compendium/index.asp>.

### 2016 OIG Top Management and Performance Challenges Facing HHS

1. Ensuring Program Integrity in Medicare Parts A and B
2. Effectively Administering the Medicaid Program to Improve Oversight of Managed Care, Address High Improper Payments, and Strengthen Program Integrity
3. Health Information Technology and the Meaningful and Secure Exchange and Use of Electronic Information
4. Improving Financial and Administrative Management
5. Ensuring the Proper Administration of HHS Grants for Public Health and Human Services Programs
6. Curbing the Abuse and Misuse of Controlled and Non-controlled Drugs in Medicare Part D and Medicaid
7. Ensuring Quality of Care and Safety for Vulnerable Populations
8. Operating and Overseeing the Health Insurance Marketplaces
9. Managing Delivery System Reform and Strengthening Medicare Advantage
10. Ensuring the Safety of Food, Drugs, and Medical Devices

In this presidential transition year, HHS must address these challenges while undertaking the additional important responsibility of conducting a well-orchestrated transition to new leadership, consistent with the executive order on “Facilitation of a Presidential Transition” and other requirements. The transition will require heightened focus on effective coordination across HHS operating divisions, continuity of operations, and emergency preparedness. This transition must be accomplished while maintaining and strengthening HHS’s many complex programs and protecting and serving its beneficiaries.

## Top Management Challenge #1: Ensuring Program Integrity in Medicare Parts A and B

### Why This Is a Challenge

Spending under Medicare Parts A and B is expected to increase significantly over time due to the growth in the number of beneficiaries and the increase in per capita health care costs. The 2016 Annual Report by Medicare's Board of Trustees estimates that the Trust Fund for Part A will be depleted by 2028. The report also projects Part B spending growth of almost 7 percent over the next 5 years, outpacing the projected 5 percent growth of the U.S. economy during that time. Further, the Part B payment system for providers is undergoing substantial changes through the Medicare Access and CHIP Reauthorization Act of 2015 and other reforms. (For more information on Medicare payment and delivery reform, see TMC #9.) HHS faces challenges—and opportunities—in each of the key areas addressed below.

### Key Components of the Challenge

- Reducing improper payments
- Preventing, detecting, and responding to fraud
- Fostering prudent payment policies

### Key Components of the Challenge

**Reducing Improper Payments.** In FY 2015, the Centers for Medicare & Medicaid Services (CMS) reported an improper payment rate of 12.1 percent, corresponding to \$43.3 billion, for Medicare Fee-for-Service (Parts A and B). These measures include payments that were paid at an incorrect amount (including both overpayments and underpayments), as well as payments for unnecessary services, services not rendered, billing or coding errors, and claims that did not meet documentation or other Medicare coverage requirements. (For more information on improper payment rate measurement and reporting, see TMC #4.)

While OIG reviews all areas of improper payments, OIG efforts in recent years have focused on specific provider areas based on risk and program size. Our reviews of hospitals' compliance with and risk of not complying with Federal and State requirements have served an important role in highlighting vulnerabilities in hospital billings and returning improper payments to the Medicare Trust Fund. OIG has also focused attention on improper payments in home health and hospice care due to concerns about vulnerabilities in these areas. Through compliance audits of home health agencies, OIG has uncovered improper payments across a number of risk areas, such as insufficient documentation, medical necessity, and homebound determinations. With respect to hospice, OIG found that one-third of stays for hospice general inpatient care in 2012 did not meet Medicare requirements, costing \$268 million. (For more information on the quality of care in home health and hospice, see TMC #7.)

In addition, OIG has focused efforts on improper payments to Part B providers, such as chiropractors, physical therapists, and certain durable medical equipment (DME) suppliers (e.g., power mobility device suppliers). Historically, these providers have had high improper payment rates, and OIG has identified error rates exceeding 50 percent in its reviews of them.

**Preventing, Detecting, and Responding to Fraud.** Curbing fraud is vital to protecting beneficiaries and conserving scarce health care resources. Fraud schemes can shift over time, but certain Medicare services have been consistent targets. Program areas susceptible to widespread fraud include home health and hospice services and DME. Common schemes include billing for unnecessary services or services not provided and kickbacks to recruiters and patients. Other concerns include aggressive and

illegal DME telemarketing and social targeting of Medicare beneficiaries, which can result in financial loss to Medicare and beneficiaries being put at risk of medical identity theft.

To help prevent fraud, Medicare must have accurate information about the individuals and entities with which it does business and must take appropriate steps to avoid doing business with, and exposing beneficiaries to, those who are untrustworthy. To this end, CMS must fully and effectively deploy all available program integrity tools, including those provided under the Patient Protection and Affordable Care Act, such as enhanced screening of provider enrollments. However, OIG found weaknesses in Medicare contractors' administration of provider enrollments that could leave Medicare vulnerable to billing by ineligible providers and beneficiaries vulnerable to seeking care from substandard providers. The weaknesses included gaps in the verification of key information, inconsistencies in site visit procedures, and failures to use site visit results for enrollment decisions. Further, CMS's Provider Enrollment, Chain and Ownership System (PECOS) is incomplete and, in some cases, inaccurate. The information in PECOS is intended to aid CMS in tracking enrollment and revalidation trends and to help determine whether CMS contractors are meeting requirements.

**Fostering Prudent Payment Policies.** In certain contexts, Medicare pays significantly different amounts for the same services provided to similar patients in different settings. For example, we estimated that during calendar year 2010 swing-bed services provided at 90 percent of the critical access hospitals (CAHs) we reviewed could have been provided at other nearby facilities that are paid under the Skilled Nursing Facility (SNF) Prospective Payment System. We believe that Medicare could have saved \$4.1 billion over 6 years if payments for swing-bed services at CAHs were made to other facilities at SNF rates. Medicare and beneficiaries also typically pay more for a physician service provided in a "provider-based facility" (i.e., one owned by a hospital) than for the same service provided in an independent facility. OIG has highlighted weaknesses in CMS's management of these payment policies.

CMS is implementing a significant overhaul of the payment system for clinical laboratory tests pursuant to the Protecting Access to Medicare Act of 2014. The new system, which seeks to better align Medicare reimbursement for lab tests with market rates, takes effect on January 1, 2018. Before then, CMS must complete numerous tasks associated with collecting private payer data from labs and using it to establish the new reimbursement rates for lab tests. Timeframes for some of these tasks are tight, e.g., completing sub-regulatory guidance before the data-reporting period begins on January 1, 2017. Further, OIG has raised concerns about risks to payment accuracy on the basis of CMS's plans to rely on labs to self-identify whether they meet the criteria for reporting private payer data and CMS's plans to rely on reporting labs' self-attestations of the data's completeness and accuracy.

Some payment systems create financial incentives that may negatively affect patient care and drive up Medicare costs. For example, Medicare's payment policies for SNFs gives these facilities incentives to bill for higher levels of therapy than beneficiaries need. OIG work showed that SNFs have billed for the highest level of therapy at increasing rates that were not supported by patient needs. Additionally, hospices provided care much longer and received much higher Medicare payments for beneficiaries in inpatient assisted living facilities (ALFs) than for beneficiaries in other settings, creating incentives for hospices to target these patients. OIG found that Medicare payments for hospice care in ALFs more than doubled in 5 years, totaling \$2.1 billion in 2012.

#### Progress in Addressing the Challenge

Through the Health Care Fraud and Abuse Control (HCFAC) Program, OIG, HHS, and the Department of Justice have made substantial strides in fighting fraud, waste, and abuse in Medicare (all parts) and

Medicaid and recovering stolen and misspent funds. From 2013 to 2015, the HCFAC Program has returned \$6.10 for every \$1 invested. In FY 2015, HCFAC-funded audits and investigations resulted in expected recoveries of \$2.4 billion. To combat Medicare fraud, waste, and abuse, HHS has also taken steps to implement additional program integrity tools and many of OIG's recommendations. Specifically, in FY 2015, OIG reported potential savings of more than \$18.4 billion from legislative, regulatory, and administrative actions taken by HHS and that were supported by OIG recommendations.

CMS is implementing prior authorization models and demonstrations in certain areas to help make sure items and services are provided in compliance with Medicare coverage, coding, and payment rules. CMS has established or is implementing prior authorization processes in certain locations that cover the following: power mobility devices, repetitive scheduled non-emergent ambulance transport, and certain durable medical equipment, prosthetics, orthotics, and supplies. CMS has also begun implementing a demonstration project in five States requiring home health agencies to submit required documentation for pre-claim review to help reduce and prevent improper payments. OIG has noted reductions in Medicare billing and payments for certain services and geographic areas known for fraud risks. For example, following law enforcement activities and CMS administrative actions, billing and payments for home health services and community mental health services declined significantly from 2009 to 2014 in fraud hot spots.

Furthermore, CMS has performed actions to improve provider enrollment safeguards to protect the integrity of the Medicare program. CMS has expanded its temporary provider enrollment moratoria for home health agencies to Statewide moratoria in certain geographic locations known for significant fraud. CMS has also proposed new regulations that would use its provider and supplier information more effectively to keep out or remove providers who pose risks to Medicare and its beneficiaries. In FY 2016, CMS reported that it has enhanced the address verification software in PECOS to better detect vacant or invalid addresses or commercial mailing reporting agencies. Further, CMS has reported improvements in its oversight and measurement of its contractors' performance and its corrective actions regarding improper payment vulnerabilities that contractors identify.

With respect to clinical laboratory services, CMS reports significant progress in several key areas, including promulgating regulations, establishing the Advisory Panel, publishing most of the sub-regulatory guidance, and building the data collection system. Finally, CMS is working to implement new legislation that would restrict the higher payment rates for provider-based facilities to "on-campus" facilities (those within 250 yards of the main provider) and to "off-campus" facilities that were designated as such before November 2, 2015.

#### **What Needs To Be Done**

Despite progress in some key areas, more must be done to protect Medicare from fraud, waste, and abuse and extend the solvency of the program. CMS could do more to ensure that fraudulent or abusive providers are not allowed to enroll or remain in Medicare in order to help prevent inappropriate payments, protect beneficiaries, and reduce the need for collection efforts against fraudulent providers who abscond with ill-gotten Medicare funds. CMS must continue improving its oversight and the performance of contractors in implementing Medicare provider enrollment safeguards, ensuring payment accuracy, and identifying and recovering overpayments in a timely manner. CMS should also improve the completeness, accuracy, and timeliness of its provider ownership data (maintained in PECOS) to support effective oversight.

HHS should continue to address and resolve program integrity weaknesses identified. OIG has recommended numerous actions, which remain unimplemented, to reduce improper payments for specific services. For example, OIG has recommended that CMS increase its oversight of hospice general inpatient claims, ensure that a physician is involved in the decision to use this level of care, and conduct prepayment reviews for lengthy stays. OIG has also recommended strengthened safeguards to ensure that Medicare pays for home health services only when the beneficiary meets the applicable homebound requirement and the home health agency has provided reasonable and necessary skilled services that are supported by and documented in the physician's certification plan.

OIG has also recommended changes to promote more prudent payment policies, including payments to hospital outpatient departments and ambulatory surgical centers, SNFs, and hospices. Many of these changes would require new statutory authority, and HHS's role is to develop legislative proposals for consideration by the Administration and Congress. Concurrently, OIG has recommended numerous actions that CMS can take within its existing authorities to mitigate the financial and quality of care risks under the current systems. For example, OIG recommended that CMS analyze billing data to identify SNFs that appear to be overbilling for therapy and expand its oversight reviews of those SNFs.

For laboratory tests, CMS must maintain focus on key remaining tasks, including completing the data collection system, ensuring completeness and accuracy of reported data, and establishing new Medicare payment rates after labs report data in 2017. CMS should monitor labs' reporting to ensure that all required labs' report data are accurate and complete. In the longer term, CMS should monitor the new system to ensure that it is meeting its cost savings goals.

#### Key OIG Resources

- OIG Testimony, "Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers," May 2016. (<https://oig.hhs.gov/testimony/docs/2016/maxwell-testimony05242016.pdf>)
- OIG Report, "Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities," January 2015. (<https://oig.hhs.gov/oei/reports/oei-02-14-00070.pdf>)
- OIG Report, "Medicare Compliance Review of Sea View Health Care Services, Inc.," May 2016. (<https://oig.hhs.gov/oas/reports/region2/21401027.pdf>)
- OIG Report, "The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated," September 2015. (<https://www.oig.hhs.gov/oei/reports/oei-02-13-00610.pdf>)
- OIG Report, "Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases," June 2016. (<https://oig.hhs.gov/oei/reports/oei-05-16-00031.pdf>)

## Top Management Challenge #2: Effectively Administering the Medicaid Program to Improve Oversight of Managed Care, Address High Improper Payments, and Strengthen Program Integrity

### Why This Is a Challenge

With over 72 million enrolled individuals, Medicaid serves more enrollees than any other Federal health care program and represents one-sixth of the national health economy. Effectively administering the Medicaid program takes on heightened urgency as the program expands under the Patient Protection and Affordable Care Act (Affordable Care Act) and undergoes other significant modernization reforms. The Centers for Medicare & Medicaid Services (CMS) reported that Federal and State Medicaid expenditures are projected to increase at an average annual rate of 6.4 percent and reach \$921 billion by 2024.

Effectively administering Medicaid continues to be a top management challenge for HHS, given the needs of the beneficiaries served and longstanding vulnerabilities related to oversight of Medicaid managed care; high improper payment rates; and harnessing program integrity tools, including data, to protect the program from fraud, waste, and abuse.

### Key Components of the Challenge

- Oversight of Medicaid managed care
- Reducing improper payment rates
- Strengthening program integrity to protect against fraud, waste, and abuse

### Key Components of the Challenge

**Oversight of Medicaid Managed Care.** The vast majority of Medicaid beneficiaries are enrolled in managed care. OIG has identified challenges to ensuring that these beneficiaries have access to high-quality care and that Medicaid funds are expended properly. For instance, OIG has found that varying State standards for access (e.g., States range from requiring one primary care provider for every 100 to 2,500 enrollees) and limited appointment availability may limit beneficiary access to services. OIG has also found that CMS does not have complete and timely managed care data from State Medicaid agencies. These data are necessary to identify and address possible fraud, waste, and abuse.

**Improper Payment Rates Are High.** Reducing improper payments to providers is a critical element in protecting the financial integrity of the Medicaid program. In FY 2015, HHS did not meet its established improper payment target for Medicaid. HHS set a FY 2015 target of 6.7 percent for Medicaid. However, the actual improper payment rate for FY 2015 was 9.8 percent. Although not all improper payments are fraud, all improper payments pose a risk to the financial security of the Medicaid program.

**Program Integrity Needs Strengthening.** CMS and State Medicaid agencies have a shared responsibility to ensure that Medicaid expenditures are spent appropriately and also to protect the program from fraud, waste, and abuse. However, OIG has found that the Affordable Care Act's screening tools designed to strengthen provider enrollment were not fully implemented by State Medicaid agencies. In addition, OIG has found that CMS's national Medicaid database—essential to effective program oversight—is incomplete and additional data are needed to enhance national program integrity activities. *(For more information on improving the flow of complete, accurate, and timely information, see TMC #3.)* Finally, OIG identified significant and persistent vulnerabilities related to personal care services (PCS), including ineffective program safeguards to ensure that beneficiaries are not exposed to unsafe or suboptimal care and Medicaid is not exposed to high improper payments. *(For more information on ensuring quality in PCS and other services, see TMC #7.)*



### Progress in Addressing the Challenge

**New Medicaid Managed Care Regulations.** In May 2016, CMS issued a Medicaid Managed Care Final Rule. The rule addressed numerous OIG recommendations and will strengthen oversight of managed care entities by improving accountability and transparency. For example, the rule expanded requirements for managed care organizations to report data related to utilization and quality of services. The rule also requires State Medicaid agencies to develop and implement provisions ensuring that beneficiaries have adequate access to Medicaid covered services. Once provisions are implemented, State Medicaid agencies will be required to annually validate network adequacy.

**Improper Payment Rate Corrective Action Plans.** CMS determined that the primary reasons for the high FY 2015 improper payment rate errors were related to State Medicaid agencies' difficulties coming into compliance with new requirements. These include enrolling all referring or ordering providers, screening providers under the Affordable Care Act risk-based screening process, and including the attending provider National Provider Identifier on all electronically-filed institutional claims. CMS has engaged with State Medicaid agencies to develop State-specific corrective action plans that address these reasons for the high improper payment rate. CMS has also facilitated national best practice calls to share ideas across States, offered ongoing technical assistance, and provided additional guidance, as needed, to address the root causes of these improper payments.

**CMS Working with States to Implement Program Integrity Measures.** CMS indicated that it is taking actions to address provider enrollment vulnerabilities identified by OIG. CMS recently released guidance, "Medicaid Provider Enrollment Compendium," to assist State Medicaid agencies in implementing disclosure requirements and the Affordable Care Act's screening and enrollment requirements. Furthermore, CMS's final rule on managed care requires State Medicaid agencies to screen and enroll all network providers. This new requirement is a significant step in addressing a large number of providers previously exempt from State Medicaid agencies' screening and enrollment requirements. CMS continues to work with States to improve Medicaid data. Specifically, CMS works with all State Medicaid agencies to submit complete, accurate, and timely data. In addition, CMS conducted focused reviews of State Medicaid agencies' high-risk program integrity areas, including State Medicaid agencies' implementation of provider enrollment and screening provisions of the Affordable Care Act. Finally, CMS is assessing what actions it can implement to address the longstanding and persistent PCS vulnerabilities identified by OIG.

### What Needs To Be Done

**Full Implementation of the Medicaid Managed Care Regulation.** CMS's issuance of the Medicaid Managed Care Final Rule is a positive step in addressing the managed care vulnerabilities identified by OIG. The final rule is the first major update to Medicaid managed care regulations in more than a decade. To facilitate full implementation of the final rule, CMS should continue to provide guidance to State Medicaid agencies in a timely manner and work closely with them to develop effective strategies to meet new requirements.

**Reduce the Improper Payment Rate.** CMS should continue its engagement with State Medicaid agencies to develop corrective action plans. Moreover, CMS should ensure that State Medicaid agencies are implementing and monitoring the effectiveness of their corrective action plans. Finally, CMS should continue innovative approaches, such as the creation of the Program Integrity Board, which leverages multiple CMS resources to identify payment vulnerabilities.

**Ensure States Fully Implement Program Integrity Measures.** CMS should continue to work with State Medicaid agencies to fully implement Affordable Care Act-required program integrity tools. Full implementation of these tools is critical to safeguarding the Medicaid program. CMS must ensure that State Medicaid agencies rigorously screen providers and make accurate beneficiary eligibility determinations. CMS should also continue to work with State Medicaid agencies to ensure that the submission of all required Medicaid data is complete, accurate, and timely. Finally, CMS must do more to address vulnerabilities in home- and community-based services, such as PCS. OIG recommends that CMS take a more active role to promote program integrity in PCS by promulgating regulations to, among other things, establish minimum qualifications and require attendants to undergo background checks and enroll in Medicaid or register with State Medicaid agencies.

#### Key OIG Resources

- OIG Testimony, “Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers,” May 2016. (<https://oig.hhs.gov/testimony/docs/2016/maxwell-testimony05242016.pdf>)
- OIG Report, “Personal Care Services: Trends, Vulnerabilities and Recommendations for Improvement – A Portfolio,” November 2012. (<http://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf>)
- OIG Report “Access to Care: Provider Availability in Medicaid Managed Care,” December 2014. (<https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>)
- OIG Report, “Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System,” September 2013. (<https://oig.hhs.gov/oei/reports/oei-05-12-00610.pdf>)
- OIG Report, “Providers Terminated from One State Medicaid Program Continued Participating in Other States,” August 2015. (<https://oig.hhs.gov/oei/reports/oei-06-12-00030.pdf>)



## Top Management Challenge #3: Health Information Technology and the Meaningful and Secure Exchange and Use of Electronic Information

### Why This Is a Challenge

In support of its mission and operations, HHS maintains and uses expanding amounts of sensitive information. Complete, accurate, and timely data can help ensure efficient operations of HHS and its programs, as well as support proactive program oversight. Similarly, the American health care system increasingly relies on health information technology (health IT) and the electronic exchange and use of health information. Health IT, including electronic health records (EHRs), offers opportunities for improved patient care, more efficient practice management, and improved overall public health. However, HHS continues to face a number of significant challenges in this information-rich environment.

### Key Components of the Challenge

- Ensuring privacy and security of information
- Improving the flow of complete, accurate, and timely information
- Delivering on the promise of Health IT

### Key Components of the Challenge

**Ensuring Privacy and Security of Information.** Safeguarding privacy and ensuring data security—both physical and cyber security—are, and should remain, top priorities for HHS. HHS must ensure that the data it creates and maintains are protected. Equally important is the need to ensure appropriate protection of health information when considering and implementing policies related to the adoption of health IT and the exchange, storage, and use of electronic health information. The rapid pace at which technology evolves, the continuing expansion of the Internet of Things (including networked medical devices), and the rise of mobile health technology contribute to the complexity of the privacy and security challenges facing HHS.

The frequency of notable data breaches has increased significantly, and ransomware has emerged as a considerable threat in the health care space. Data breaches can have serious consequences for the health care industry, HHS, and those whom HHS serves. Threats to the confidentiality, integrity, and availability of data can result in a range of harms, including financial harm (to individuals and the public), identity theft, and physical patient harm. Frequently-identified weaknesses include inadequacies in access controls, patch management, encryption of data, and website security vulnerabilities at HHS, health care providers, States, and other entities that do business with HHS. Such weaknesses could impact the Department's ability to protect against unauthorized access to sensitive information. HHS is also responsible for implementing certain provisions of the Cybersecurity Act of 2015, as well as the Continuous Diagnostics and Mitigation program in conjunction with the Department of Homeland Security (DHS). When implementing technology, including complex, interoperable IT systems, HHS must utilize modern IT practices, such as those highlighted by the [Digital Services Playbook](#).

**Improving the Flow of Complete, Accurate, and Timely Information.** To capitalize on growing amounts of data in the health care context,<sup>30</sup> there must be meaningful access, subject to appropriate privacy and security safeguards, to complete, accurate, and timely data, where and when needed. However, enabling and encouraging the flow of information remains a challenge for HHS. Several factors may impede the flow of information. These include technical barriers (e.g., lack of interoperability), the

<sup>30</sup> Sources of relevant health care data, including patient-generated data, are ever increasing, particularly as the Internet of Things continues to expand.

complex nature of Federal and State privacy and security laws, financial considerations (e.g., the cost of health IT acquisition), and behavioral issues—such as information blocking<sup>31</sup> and consumer confidence—that relate to a willingness to share information.

Impediments to information sharing can present patient safety concerns. For example, a patient could be subjected to additional invasive testing that could have been avoided had information about prior results held by a different provider been shared. Improving the appropriate flow of health information among providers, patients, and those delivering related services is also critical to the success of many delivery reform and other initiatives, including the President's Precision Medicine Initiative (PMI) and the Cancer Moonshot. Without appropriate information sharing, those who participate in the initiatives may face challenges in achieving initiative goals. *(For more information on health care delivery reforms, see TMC #9.)*

The flow of information is also important between HHS and others, including providers. For example, data created, maintained, or transmitted using EHRs or other health IT are used to ensure correct Medicare and Medicaid payments, including value-based payments. Participants in certain initiatives also receive Departmental data for their use in improving the care they furnish. Additionally, HHS increasingly uses and shares data as part of its program operations and program integrity efforts. HHS must continue to find ways to leverage the vast amounts of data at its disposal to enhance decision-making, including streamlining and accelerating internal data exchange. Similarly, it is critical that HHS ensure that the systems on which it relies, including Medicare and Medicaid systems, are developed and operate in a way that ensures that the data are complete, accurate, timely, and appropriately protected. Prior OIG work has raised concerns about, for example, the completeness and accuracy of Transformed Medicaid Statistical Information System (T-MSIS) data.

***Delivering on the Promise of Health IT.*** HHS has made significant investments in health IT.<sup>32</sup> However, HHS faces challenges in ensuring that the goals associated with investing in the widespread adoption and use of EHRs and other health IT are fulfilled, and that the promise offered by health IT is realized. These challenges are in addition to the challenges of ensuring privacy and security and improving the flow of complete, accurate, and timely information. They include preventing inappropriate payments to participants who do not meet program requirements; ensuring that the beneficial characteristics of EHRs, including efficiency and ease of storage and access, are not used as tools for fraud; encouraging adoption and use of health IT by those who are not eligible for existing incentive programs; ensuring that patient safety benefits are realized; and encouraging the use of data that are exchanged.<sup>33</sup> Connecting the entire continuum of those involved in health care, as well as human services, is important to leveraging the benefits of health IT in a value-driven health care system. *(For more information on health delivery reforms, see TMC #9.)* Also important is ensuring that the underlying data

<sup>31</sup> For more information on the topic of information blocking, see The Office of the National Coordinator for Health Information Technology's (ONC) Report to Congress, "Report on Health Information Blocking," April 2015. ([https://www.healthit.gov/sites/default/files/reports/info\\_blocking\\_040915.pdf](https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf)).

<sup>32</sup> For example, in connection with the PMI, the National Institutes of Health (NIH) issued \$55 million in grants, some of which will be used to establish a data and research support center and a participant technologies center. (<https://www.nih.gov/news-events/news-releases/nih-awards-55-million-build-million-person-precision-medicine-study>)

<sup>33</sup> ONC noted the need to improve the use of exchanged information by non-Federal acute care hospitals. ONC, Data Brief, No. 36, "Interoperability among U.S. Non-federal Acute Care Hospitals in 2015," May 2016. ([https://www.healthit.gov/sites/default/files/briefs/onc\\_data\\_brief\\_36\\_interoperability.pdf](https://www.healthit.gov/sites/default/files/briefs/onc_data_brief_36_interoperability.pdf))

are robust enough to be leveraged for important research and regulation.<sup>34</sup> When addressing these challenges, HHS must ensure coordination among internal agencies, as well as other Federal partners, with overlapping responsibility for various aspects of health IT to avoid potential gaps in policy and oversight that could undermine the promise of the health IT in which HHS has invested.

### Progress in Addressing the Challenge

HHS has made progress with respect to privacy and security of its systems and information. Last year, HHS participated in the U.S. Chief Information Officer's 30-day Cybersecurity Sprint. More recently, HHS adopted DHS's Continuous Diagnostics and Mitigation program and is in the process of implementing EINSTEIN 3A.

Similarly, HHS has made progress regarding the privacy and security of external health information. For example, HHS participated in the development of the PMI: Data Security Policy Principles and Framework; the Food and Drug Administration (FDA) held a public workshop with DHS concerning medical device cybersecurity; HHS's coordination with the Federal Trade Commission led to the issuance of new resources for health IT developers, including some related to privacy and security; HHS, in conjunction with other Federal agencies, issued ransomware guidance discussing best practices; and the Office for Civil Rights (OCR) released a Fact Sheet on the Health Insurance Portability and Accountability Act (HIPAA) and ransomware. Further, HHS has taken steps to implement portions of the Cybersecurity Act of 2015, including convening a health care industry cybersecurity task force.

HHS has made great strides in developing a nationwide health IT infrastructure that supports the appropriate flow of complete, accurate, and timely information. As of September 2016, more than 599,000 eligible professionals, eligible hospitals, and critical access hospitals were actively registered in the EHR incentive programs.<sup>35</sup> Additionally, HHS has made a concerted effort to empower patients with respect to accessing their electronic health information.<sup>36</sup> HHS continues to focus on liberating health data in order to improve patient outcomes and health care delivery as well as social services. A sample of some of HHS's data initiatives include the Centers for Medicare & Medicaid Services' (CMS) release of new and updated public use files related to physician payment data and interactive online tools (such as the Medicare Part D Opioid Drug Mapping Tool and Mapping Medicare Disparities Tool); NIH's Genomic Data Commons platform to store, analyze, and distribute cancer genomics data; FDA's openFDA now allows direct downloads of data (openFDA offers access to medical device reports, enforcement reports, and drug adverse event reports); and Centers for Disease Control and Prevention's publically available data repository related to the ongoing Zika epidemic. The year 2016 also marked the 7<sup>th</sup> Annual Health Datapalooza, which brought together startups, academics, Government agencies, and individuals.<sup>37</sup>

<sup>34</sup> FDA, for example, issued draft guidance concerning the use of real-world evidence to support regulatory decision-making for medical devices, which notes that "[real-world data] and associated [real world evidence] could constitute valid scientific evidence, depending on the characteristics of the data."

(<http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/UCM513027.pdf>)

<sup>35</sup> CMS "State Breakdown of Registration by Medicaid and Medicare Providers through September 30, 2016," September 2016.

<sup>36</sup> OCR issued a Fact Sheet (<http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html>); ONC and OCR released educational videos (<https://www.healthit.gov/access>); and ONC issued a patient engagement playbook (<https://www.healthit.gov/playbook/pe/>).

<sup>37</sup> HHS also collaborated with Health Datapalooza to add a post-conference day devoted to health IT privacy and security. (<https://www.healthit.gov/buzz-blog/privacy-and-security-of-ehrs/new-health-datapalooza-2016-day-devoted-privacy-security/>)

With respect to information blocking, HHS established a hotline to receive complaints concerning potential information blocking practices and issued a final rule implementing related attestation requirements under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Further, HHS obtained commitments from providers of hospital EHRs, large private health systems, and leading professional associations and stakeholder groups to make EHRs work better for patients and providers. One of the areas of commitment relates to avoiding information blocking.

HHS's participation and leadership in the Healthcare Fraud Prevention Partnership (HFPP) continues to improve the flow of information to address program integrity issues. The HFPP, a public-private partnership, brings interested parties—including private insurers, public payors, law enforcement agencies, and others—together to share and use data and analytic tools to proactively address health care fraud, waste, and abuse. Further, HHS continues to work with States to improve Medicaid data that are essential for protecting program integrity. Specifically, CMS issued a final rule in December 2015 authorizing the withholding of a subset of Federal funds for Medicaid administration from States until T-MSIS data are reported as required and information systems meet operability standards. In addition, CMS has established standards for the completeness, accuracy, and timeliness of T-MSIS data. According to CMS, it is in the process of implementing T-MSIS with all states, and there are 18 states in production as of September 2016. CMS also reports that it anticipates T-MSIS data to be available for the various stakeholders in early 2017 subject to state T-MSIS transition timelines.

HHS has continued to oversee the Medicare and Medicaid EHR incentive programs and has endeavored to advance the national conversation about important health IT issues to ensure that the potential benefits of health IT investments are realized.<sup>38</sup> HHS has also finalized a rule to implement the MACRA provisions that replace the Medicare EHR Incentive Program for eligible professionals with the Advancing Care Information Performance Category of the Merit-based Incentive Payment System (MIPS).

### What Needs To Be Done

Threats to information privacy and security are evolving, as evidenced by the recent rise of ransomware, and HHS must remain vigilant. While HHS has made progress with respect to protecting its own information, as highlighted in OIG work and a congressional report from 2015, more remains to be done. OIG work will continue to focus on HHS systems' privacy and security to support HHS's efforts to mitigate the risk of unauthorized access to its sensitive information. HHS must also use available policy levers to address health IT privacy and security issues. OIG work released in 2016 examined HIPAA-required contingency planning for hospitals' EHRs and discussed the role contingency plans can play in preventing and mitigating disruptions caused by ransomware and other problems. Phase 2 of OCR's HIPAA Audit Program, which it launched in 2016, and OCR's efforts to increase investigations of smaller

<sup>38</sup> Last year, ONC issued a document entitled "Connecting Health and Care for the Nation: A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure" (<http://healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf>) (10-Year Vision Paper), which describes plans to expand the sharing of information for health beyond EHRs and identifies privacy and security protections for health information as a building block for a nationwide interoperable health information infrastructure. More recently, ONC issued a document entitled "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0," (<https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>) which supports the vision laid out in the 10-Year Vision Paper. ONC has also issued an information-blocking report to Congress, ([https://www.healthit.gov/sites/default/files/reports/info\\_blocking\\_040915.pdf](https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf)), a Health IT Safety Center Roadmap (<http://www.healthitsafety.org/uploads/4/3/6/4/43647387/roadmap.pdf>), and an updated Federal Health IT Strategic Plan for 2015–2020 ([http://www.healthit.gov/sites/default/files/9-5-federalhealthitstratplanfinal\\_0.pdf](http://www.healthit.gov/sites/default/files/9-5-federalhealthitstratplanfinal_0.pdf)).

breaches (those involving fewer than 500 individuals)<sup>39</sup> are additional activities that will bring attention to health IT privacy and security. OIG work will continue to focus on privacy and security issues in the regulated community and on the related agencies to address concerns about similar risks for health information. Ongoing work is considering privacy and security issues related to networked medical devices, and future work may consider additional privacy and security issues that arise from the continuing expansion of the Internet of Things.

To reach HHS's goals, including goals related to achieving the learning health system identified in ONC's 10-Year Vision Paper and those associated with the PMI and Cancer Moonshot, HHS must do more to improve the flow of complete, accurate, and timely information, subject to appropriate privacy and security safeguards. This includes ensuring that HHS's data systems are developed and operated in a way that delivers complete, accurate, and timely data. HHS must also find ways to remove potential barriers to leveraging health IT and related data to advance public health initiatives and to facilitate sharing and use of information along the entire continuum of care (beyond just those who are eligible for EHR incentives).

Finally, to deliver on the promise of health IT, and given the magnitude of the investment in EHRs and other health IT programs, it will become increasingly important to measure the extent to which EHRs and health IT have achieved HHS's goals, which include improved health care and lower costs. As HHS develops policies, such as those related to the development and implementation of meaningful use stages and implementation of the Advancing Care Information Performance Category of MIPS created in MACRA, it should continue to consider feedback from stakeholders to ensure that adopted policies advance the Nation toward HHS's stated goals, while appropriately reflecting the rapidly changing health IT landscape and balancing privacy and security considerations. Additional guidance and technical assistance should be issued to address adoption, meaningful use, interoperability barriers, and program integrity safeguards. It is also essential that privacy, security, and fraud prevention remain at the forefront of health IT efforts of HHS, ONC, OCR, and CMS. Ongoing OIG work is examining the accuracy of Medicare and Medicaid EHR incentive payments for meaningful use and health IT interoperability across providers participating in accountable care organizations. Future work may also examine health IT interoperability across HHS and between providers and patients as well as outcomes from health IT investments.

#### Key OIG Resources

- OIG Summary Report, "Wireless Penetration Test of Centers for Medicare & Medicaid Services' Data Centers," August 2016. (<https://oig.hhs.gov/oas/reports/region18/181530400.asp>)
- OIG Report, "Hospitals Largely Reported Addressing Requirements for EHR Contingency Plans," July 2016. (<https://oig.hhs.gov/oei/reports/oei-01-14-00570.asp>)
- OIG Report, "Not All States Reported Medicaid Managed Care Encounter Data as Required," July 2015. (<https://oig.hhs.gov/oei/reports/oei-07-13-00120.asp>)
- OIG Report, "CMS and Its Contractors Have Adopted Few Program Integrity Practices To Address Vulnerabilities in EHRs," January 2014. (<https://oig.hhs.gov/oei/reports/oei-01-11-00571.asp>)
- OIG Report, "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology," December 2013. (<https://oig.hhs.gov/oei/reports/oei-01-11-00570.asp>)

<sup>39</sup> OCR listserv email from August 19, 2016, entitled "OCR Announces Initiative to More Widely Investigate Breaches Affecting Fewer than 500 Individuals," available at <https://list.nih.gov/cgi-bin/wa.exe?A2=OCR-PRIVACY-LIST;65d278ee.1608>.

## Top Management Challenge #4: Improving Financial and Administrative Management

### Why This Is a Challenge

HHS is the largest civilian agency within the Federal Government. In FY 2015, HHS reported total costs of approximately \$1 trillion. Responsible stewardship of HHS programs is vital, and operating a financial management and administrative infrastructure that employs appropriate safeguards to minimize risk and provide oversight for the protection of resources remains a challenge for HHS. HHS must also ensure the completeness, accuracy, and timeliness of any financial and program information provided to other entities, both internal and external to the Federal Government.

### Key Components of the Challenge

- Addressing weaknesses in financial management systems
- Reducing improper payments
- Improving contracts management
- Implementing DATA Act standards.

### Key Components of the Challenge

**Financial Management Systems.** We continue to report a material weakness in HHS's financial management systems related to inadequate internal controls over segregation of duties, configuration management, and access to HHS financial systems. HHS still does not substantially comply with financial management system requirements due to these issues. Under the Federal Financial Management Improvement Act of 1996, Federal agencies must establish and maintain financial management systems, and Inspectors General must determine compliance by their respective agency. These systems are intended to help agencies ensure the effectiveness and efficiency of operations, reliability of financial reporting, and compliance with applicable laws and regulations.

**Improper Payments.** Reducing improper payments is a critical element in protecting the financial integrity of HHS programs. Although not all improper payments are fraud, all improper payments pose a risk to the financial security of Federal programs. Pursuant to the Improper Payments Information Act of 2002 (IPIA), as amended, Federal agencies are required to provide uniform, annual reporting on improper payments and their efforts to reduce them. In its most recent Agency Financial Report (AFR), HHS reported improper payments totaling \$89.7 billion overall for FY 2015 (excluding Superstorm Sandy programs). Our audit of HHS's FY 2015 AFR, published in May 2016, found that HHS did not meet all IPIA requirements. Specifically, we found that HHS did not report an improper payment rate for the Temporary Assistance for Needy Families (TANF) program, reported that the improper payment rate exceeded 10 percent for the Medicare Fee-for-Service program, reported four other risk-susceptible programs that did not meet their FY 2015 target error rates, and did not perform a risk assessment of payments to employees and charge card payments. HHS does not have the statutory authority to collect data from States that is necessary for calculating a TANF improper payment rate.

**Contracts Management.** HHS is one of the largest contracting agencies in the Federal Government. Given the high dollar amount and complexity of contracts, it is paramount that HHS have strong monitoring and oversight. OIG has raised issues about acquisition planning and procurement, contract monitoring, and payments to contractors related to the Federal Health Insurance Marketplaces operated by the Centers for Medicare & Medicaid Services (CMS). OIG has also identified issues regarding contract closeouts. OIG found that CMS had not closed out contracts totaling \$25 billion, as required by the Federal Acquisition Regulation. Because the closeout process is typically the final



opportunity for improper payments to be detected and recovered, delays in the closeout process pose a substantial financial risk. Additionally, OIG has identified weaknesses in CMS's oversight and performance measurement for its benefit integrity contractors.

**Digital Accountability and Transparency Act.** The Digital Accountability and Transparency Act (DATA Act) required the Office of Management and Budget (OMB) and Department of the Treasury to establish Governmentwide data standards for reporting financial and payment information by May 2015. Broadly, the DATA Act requires HHS to begin using the Governmentwide data standards to enter information into USA Spending by May 2017 in an effort to ultimately increase transparency and accountability. Our readiness review of HHS's implementation of the DATA Act as of June 30, 2016, found that although HHS made progress, they have not fully met the requirements of the four initial steps of Treasury's *Agency 8-Step Plan*. Specifically, we found that HHS did not complete detailed project plans or determine how it will certify that the data is accurate and complete. Given the difficulty of defining and developing common data elements across multiple reporting areas and the volume of diverse programs administered by HHS, we determined that HHS will face challenges implementing these uniform data standards within the required timeframe.

#### Progress in Addressing the Challenge

HHS has taken corrective actions to resolve the information technology-related deficiencies reported in the AFR. In FY 2015, senior leadership placed additional focus on this area, which has remediated a number of deficiencies related to HHS financial management systems identified in past audits. HHS reviewed and updated critical entitywide governance documentation, such as authorities that allow systems to operate, plans to account for and improve system security, and configuration management. HHS also updated application-level contingency plans and backup policies and procedures and performed testing to improve redundancy and availability of the supporting information technology infrastructure and financial application system.

HHS has stated that when legislation is considered to reauthorize TANF, HHS plans to work with Congress to address a set of issues related to accountability and how funds are used, and to craft statutory changes that would allow for reliable error rate measurement, if appropriate. HHS also stated that it would perform risk assessments of payments to employees and charge card payments in FY 2016 and publish the results in the FY 2016 AFR.

In November 2015, HHS published a final rule that updated the HHS Acquisition Regulation (HHSAR) to supplement the Federal Acquisition Regulation. The HHSAR provides additional policy and procedural guidance to foster financial integrity and accountability across the acquisition lifecycle, from the concept of need through contract closeout. Additionally, CMS reported that it has prioritized closing out contracts. Since February 1, 2014, CMS reported that it has closed 4,909 contracts with an obligated value of \$2.2 billion and de-obligated \$82.49 million.

HHS has established a DATA Act Project Management Office within the Office of the Assistant Secretary for Financial Resources. This encompasses representatives from all of its operating divisions. HHS expects that these actions will enable it to meet the May 2017 due date for implementing the Governmentwide data standards. The HHS DATA Act Program Management Office has also been appointed by OMB's Office of Federal Financial Management (OFFM) as the executing agent of the financial assistance portion of the pilot required by Section V of the DATA Act. OFFM maintains strategic oversight for the pilot, while HHS is tasked with providing tactical leadership and establishing a pilot program to inform recommendations to Congress on methods to standardize reporting elements across

the Federal Government, eliminate unnecessary duplication in financial reporting, and reduce compliance costs for recipients of financial awards.

#### **What Needs To Be Done**

HHS should continue to address and resolve financial management system weaknesses identified by OIG, the Government Accountability Office, and other auditors contracted by OIG or HHS.

In addition, HHS must meet improper payment reduction targets and reduce improper payments to less than 10 percent for all programs. HHS must conduct thorough root cause analyses of significant improper payments and develop robust corrective action plans that target identified causes. HHS also must conduct a risk assessment of payments made to employees and use of charge cards.

CMS should improve coordination and collaboration across departmental staff with contract closeout responsibilities. CMS must also ensure that acquisition strategies are completed as required. Further, CMS must strengthen its contracts oversight, including proper accounting for contract costs related to the Federal Marketplace.

HHS must implement the Governmentwide data standards established by OMB and Department of the Treasury in accordance with the timeframes established by the DATA Act. HHS must also ensure that any information provided to comply with the Governmentwide data standards is complete, accurate, and timely.

#### **Key OIG Resources**

- OIG Report, "U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did Not Fully Comply for Fiscal Year 2015," May 2016. (<https://oig.hhs.gov/oas/reports/region1/171652000.asp>)
- OIG Report on Financial Statement Audit of Health and Human Services for Fiscal Year 2015, November 2015. (<http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf>)
- OIG Report, "CMS Has Not Performed Required Closeouts of Contracts Worth Billions," December 2015. (<https://oig.hhs.gov/oei/reports/oei-03-12-00680.pdf>)
- OIG Report, "CMS Did Not Identify All Federal Marketplace Contract Costs and Did Not Properly Validate the Amount to Withhold for Defect Resolution on the Principal Federal Marketplace Contract," September 2015. (<https://oig.hhs.gov/oas/reports/region3/31403002.pdf>)
- OIG Report, "Report on the DATA Act Readiness Review Audit of the Department of Health and Human Services," November 2016. (<https://oig.hhs.gov/reports-and-publications/oas/dept.asp>)



## Top Management Challenge #5: Ensuring the Proper Administration of HHS Grants for Public Health and Human Services Programs

### Why This Is a Challenge

HHS is the largest grant-making organization in the Federal Government, with more than \$400 billion awarded in FY 2016. The Patient Protection and Affordable Care Act (Affordable Care Act) provided additional grants funding, adding to HHS's oversight responsibility. Responsible stewardship of these program dollars is vital to public health and well-being. Operating a financial management and administrative infrastructure that employs appropriate internal controls to minimize risk and protect resources remains a challenge for HHS.

### Key Components of the Challenge

- Misuse of grant funds
- Inadequate oversight of programs for children
- Inadequate oversight of preparedness and response to emergencies and infectious diseases.

Vulnerabilities exist in grants management throughout HHS. For example, awarding agencies lack effective mechanisms to share information about problematic grantees. Intra-department communication is critical, especially because awarding agencies are now required to assess risks posed by grant applicants. Additionally, awarding agencies' monitoring of grantee progress over the life of the grant continues to need improvement. Once funds are awarded, effective oversight is key in ensuring that grantees expend Federal funds properly and efficiently. Lastly, many HHS grantees lack effective internal controls, including robust financial management systems required to provide effective accountability for Federal funds. To fulfill grant responsibilities and ensure accountability of Federal funds, grantees are required to maintain internal controls that provide reasonable assurance that operations are effective and efficient, ensure reliable reporting for internal and external use, and comply with laws and regulations. In addition to its usual grants administration and oversight activities, HHS faces the challenge of updating its internal and external grants policies and systems in accordance with 45 CFR part 75, its new regulation governing grants administration and the establishment of cost principles.

Examples of specific vulnerabilities in HHS grant programs include misuse of funds, inadequate oversight of programs for children, and inadequate oversight of preparedness and response to emergencies and infectious diseases.

### Key Components of the Challenge

**Misuse of Grant Funds.** Misuse of Federal funds poses significant risks to the integrity of HHS programs. For example, in 2015 the University of Florida entered into a \$19.875 million settlement agreement with OIG and HHS to resolve allegations that the University overcharged hundreds of HHS grants for the salary costs of its employees, charged some of these grants for administrative costs for equipment and supplies when those items should not have been directly charged to the grants under Federal regulations, and inflated costs charged to HHS grants. In another example, five individuals from Montana were convicted of fraud and sentenced in 2015 after improperly receiving Temporary Assistance for Needy Families (TANF) funds from the Blackfeet Tribe of the Blackfeet Nation in Montana and from the Federally funded State welfare program simultaneously. The Administration for Children and Families (ACF) worked with OIG to pursue a misuse of funds penalty against the Tribe for lack of oversight of HHS funds in its TANF program.

***Oversight of Programs for Children.*** For HHS block grants, States are given broad flexibility to oversee and monitor funds and determine the fraud-prevention activities they will use to help ensure program integrity. OIG found that States differed in the scope and method of their program integrity and antifraud activities. For the Child Care and Development Fund (CCDF)—a \$5.7 billion program that services nearly 1.4 million children every month—OIG identified weaknesses in the fiscal controls over CCDF funds in various States and, in total, reported more than \$39.4 million in fund expenditures for FYs 2004–2010 that did not comply with Federal requirements. ACF has been working in the CCDF Block Grant structure to encourage States to adopt more uniform program integrity policies. The CCDF final rule, published on September 30, 2016, requires States to have effective procedures and practices to ensure integrity and accountability in the CCDF program. In addition, HHS oversees a variety of grantees providing for the care and services for unaccompanied children entering the United States from foreign countries and must maintain vigilance against fraud. For example, a grantee case manager in Florida defrauded more than 10 family members and/or potential sponsors of unaccompanied children who were in the custody of the Office of Refugee Resettlement by falsely representing that failing to send the case manager a requested amount of money might delay reunification with their children or result in the child’s deportation. The case worker was sentenced to 18 months of imprisonment and ordered to pay \$11,100 in restitution.

***Oversight of Grants for Emergency Preparedness and Response and for Infectious Diseases.*** Effective protection against public health threats requires a well-coordinated public health infrastructure that can rapidly respond to emergencies at home and internationally. In dealing with infectious diseases such as Zika and Ebola, proper grant mechanisms need to be in place to foster effective response coordination with domestic and international partners. Once policies are in place, awarding agencies must also ensure that funds are effectively awarded and managed. OIG found that the Centers for Disease Control and Prevention (CDC) did not always adequately document its funding decisions to award \$1.9 billion in President’s Emergency Plan for AIDS Relief funds over a 5-year project period. OIG also found that CDC may have considered applications that it should not have or treated applicants inconsistently. HHS must also ensure that grant programs allow appropriate funding flexibility to best address response needs. For example, five States received almost \$475 million in Social Services Block Grant (SSBG) funding to help cover social service and reconstruction expenses resulting directly from Superstorm Sandy. Although Sandy SSBG funds assisted States’ recovery by supporting reconstruction and social service activities, ACF’s guidance limited the effectiveness of State planning and use of the funds.

#### **Progress in Addressing the Challenge**

HHS has worked to strengthen its grants program integrity efforts. New grant regulations were codified at 45 CFR part 75, implementing Office of Management and Budget’s Uniform Guidance requirements. Pursuant to those rules, the Assistant Secretary for Financial Resources (ASFR) is implementing a single audit resolution tracking system—scheduled for completion by September 30, 2017. These rules are intended to ensure that all grant closeout activities are completed within 270 days. *(For more information on the DATA Act, see TMC #4.)* Further, ASFR issued the Grants Policy Administration Manual in December 2015, which compiles all internal grants policies in a single location.

HHS has made efforts to assess grant program performance and improve grant oversight along with identifying and reporting potential fraud, waste, and abuse in its programs. For example, the Indian

Health Service partnered with OIG to provide training for employees of HHS and tribal facilities on identifying and reporting potential fraud, waste, and abuse. HHS has increased its use of suspension and debarment authorities, resulting in an increase from 32 debarments and 7 suspensions in FY 2014 to 26 debarments, 28 proposed debarments, and 37 suspensions in FY 2015—thus preventing prohibited businesses and individuals from receiving Federal funding. HHS is actively training awarding agencies on the suspension and debarment process. In addition, HHS has partnered with OIG in presenting suspension and debarment training.

#### What Needs To Be Done

HHS needs to take more aggressive action to identify poorly performing grantees and those at risk of misspending Federal dollars and either provide increased technical assistance and monitoring or prevent them from continuing to receive grant funds. Sustained focus and information sharing is needed to monitor and address vulnerabilities, and HHS must diligently continue efforts to ensure that recipients use funds consistent with legal requirements and Departmental policies and procedures.

As HHS moves forward to implement requirements related to the new grant regulations at 45 CFR part 75 and the DATA Act, it must ensure that the HHS awarding agencies have processes and appropriate internal controls in place to effectively award, monitor, and report on grants management activities. These include the development of:

- a framework to evaluate risks posed by grant applicants that is then included in funding opportunity announcements;
- a process to correlate grantee financial data to performance accomplishments to demonstrate effective practices and improve program outcomes; and
- a system to standardize grant data elements and publicly report financial spending data for grant awards.

In addition, HHS will need to successfully implement a system to track, monitor, and resolve single audit findings to effectively carry out new management responsibilities under 45 CFR part 75.

HHS should continue to provide training on identifying and pursuing misconduct in grants. Grant officers should more actively coordinate with and refer potential fraud to OIG for investigation. HHS should continue to pursue other avenues of training beyond the classroom setting, such as webinars or podcasts, to reach a broader range of HHS staff that are located domestically and internationally. HHS also needs to continue to refine its suspension and debarment procedures by streamlining the referral and decision process, to continue providing training and decrease the processing time of referrals. Moreover, HHS needs to implement a program to actively pursue fraud under the Program Fraud Civil Remedies Act.

#### Key OIG Resources

- OIG Report, “HHS Oversight of Grantees Could Be Improved Through Better Information Sharing,” September 2015. (<https://oig.hhs.gov/oei/reports/oei-07-12-00110.asp>)
- OIG Report, “Puerto Rico Improperly Claimed Some Child Care and Development Targeted Funds,” January 2016. (<https://oig.hhs.gov/oas/reports/region2/21202016.asp>)
- OIG Report, “More Effort is Needed to Protect the Integrity of the Child Care and Development Fund Block Grant Program,” July 2016. (<https://oig.hhs.gov/oei/reports/oei-03-16-00150.asp>)

- OIG Report, "CDC Did Not Award President's Emergency Plan for AIDS Relief Funds for 2013 in Compliance with Applicable HHS Policies," May 2016.  
(<https://oig.hhs.gov/oas/reports/region4/41404021.pdf>)
- OIG Report, "Link2Health Solutions, Inc., Budgeted Costs That Were Not Appropriate and Claimed Some Unallowable Hurricane Sandy Disaster Relief Act Funds," March 2016.  
(<https://oig.hhs.gov/oas/reports/region2/21402013.asp>)

## Top Management Challenge #6: Curbing the Abuse and Misuse of Controlled and Non-controlled Drugs in Medicare Part D and Medicaid

### Why This Is a Challenge

The Centers for Medicare & Medicaid Services (CMS) oversees prescription drug coverage for 41 million Medicare Part D and more than 72 million Medicaid beneficiaries.<sup>40</sup> Part D is the fastest growing component of the Medicare program. Since its inception in 2006, Part D spending has more than doubled to \$137 billion in 2015. Medicaid expenditures for prescription drugs are also increasing, influenced by Medicaid expansion and increasing expenditures for expensive specialty drugs. In FY 2014, Medicaid spent approximately \$22 billion, 5 percent of total Medicaid spending, on prescription drugs. HHS's oversight of its prescription drug programs faces numerous challenges, affecting beneficiary and community safety and the integrity of the benefit itself.

### Key Components of the Challenge

- Questionable and inappropriate utilization of prescription drugs
- Abuse and misuse of controlled and noncontrolled substances

### Key Components of the Challenge

**Oversight.** The Part D and Medicaid prescription drug programs are large and complex. In Part D, CMS contracts with plan sponsors, which are responsible for paying claims, monitoring billing patterns, and establishing compliance plans, among other things. CMS also contracts with the Medicare Drug Integrity Contractor to detect and prevent fraud, waste, and abuse in Part D. OIG has identified challenges concerning all of the players charged with safeguarding the program. These challenges relate to (1) the need to more effectively collect and analyze program data to proactively identify and resolve program vulnerabilities and prevent fraud, waste, and abuse before it occurs; and (2) the need to more fully implement robust oversight to ensure appropriate payments, prevent fraud, and protect beneficiaries. *(For information on Medicaid's oversight challenges related to other services, see TMC #2.)*

**Drug Abuse and Diversion.** Pharmaceutical fraud and drug diversion continue to rise. In FY 2015, OIG had 571 investigative cases and pending complaints involving Medicare and Medicaid prescription drug fraud. In FY 2016, the number of investigative cases and pending complaints rose to 692. Medicaid Fraud Control Units also investigate drug diversion, and they reported to OIG that they had 553 open drug diversion cases, 117 related convictions, and \$4.3 million in recoveries related to drug diversion in FY 2015.

**Abuse and Misuse of Controlled Substances.** According to the Centers for Disease Control and Prevention, the use of opiates (drugs commonly used for pain relief) and other controlled substances has reached epidemic proportions, with more than 2 million people abusing or dependent upon prescription opioids. Nearly one in three Part D beneficiaries received commonly-abused opioids in 2015. Part D spending for these drugs reached \$4.1 billion in 2015, a 165 percent increase since the program started in 2006. In addition to concerns this trend may raise around questionable and inappropriate utilization, novel abuse methods and refinement techniques present new challenges.

<sup>40</sup> The Medicaid beneficiary total includes full and partial dual eligible recipients as well as the Children's Health Insurance Program (CHIP) recipients. Dual eligible recipients receive prescription drug benefits through Part D plans and may also be reflected in the Medicare total numbers. CHIP recipients receive drug benefits through the individual State programs.

Several HHS operating divisions are responsible for programs related to the safety and efficacy of drugs and drug abuse prevention and treatment. Effectively coordinating all Departmental efforts and prioritizing initiatives are key to combating this complex epidemic. *(For more information on challenges for the Food and Drug Administration (FDA) and Medicaid, see TMCs #10 and #2.)*

**Abuse and Misuse of Non-controlled Substances.** It is often under-recognized that many non-controlled substances are abused along with opiates to enhance euphoria. These medically-inappropriate dosages and combinations contribute to adverse events, including respiratory depression (hypoventilation) and death. Additionally, Part D spending for compounded drugs (drugs that have been combined, mixed, or altered to create a medication tailored to the needs of an individual patient) increased significantly, particularly for topical medications that have risen by 3,400 percent since 2006. This rapid growth, along with a growing number of fraud cases involving medically-unnecessary compounded drugs, could indicate an emerging fraud trend. *(For more information on ensuring Medicaid quality of care, see TMC #2, and for more information on compounded drugs, see TMC #10.)*

#### Progress in Addressing the Challenge

##### **Reducing Questionable and Inappropriate Utilization.**

CMS has taken steps to improve the oversight provided by the key players tasked with safeguarding Part D. For example, CMS updated its audit process to ensure that sponsors' compliance programs addressed all of the required compliance program elements. When implemented successfully, a compliance plan that includes a comprehensive fraud, waste, and abuse program helps plan sponsors protect the integrity of Medicare funds and may also improve the operating efficiency and effectiveness of plan sponsors. CMS is also taking steps to prevent pharmacy billing fraud and overutilization of prescription drugs. Specifically, CMS has implemented a system to reject payments for Part D prescriptions written by providers who have been excluded from Federal health care programs.

In April 2015, CMS launched Predictive Learning Analytics Tracking Outcome (PLATO), a web-based tool to allow CMS, law enforcement, and plan sponsors to share information and coordinate actions against high-risk pharmacies and prescribers.

##### **Reducing Abuse and Misuse of Controlled Substances.**

CMS started publicly sharing data to raise community awareness among providers and local public health officials about regional opioid-prescribing habits. In November 2015, CMS released an interactive online mapping tool, which shows geographic comparisons at the State, county, and ZIP code levels of Medicare Part D opioid prescriptions (excluding private and personal information). HHS has also taken actions to restrict the manufacture, possession, or use of

#### **Addressing the Rising Costs for Prescription Drugs**

The effect of high and rising prices for drugs on beneficiary costs and access to medications is a significant challenge facing the Department and the entire health care system. Rising prescription drug prices also have a significant impact on the financial health of Federal and State programs that account for a significant portion of total prescription drug spending. In 2014, Medicaid paid \$22 billion for outpatient drugs. In 2014, Medicare Part B and its beneficiaries paid more than \$21 billion for prescription drugs, and Medicare Part D paid almost \$78 billion. HHS is considering a number of policy options for both Medicare and Medicaid to address the rising cost of prescription drugs. To assist with this challenge, OIG is committed to providing information about the impact of prescription drug prices on Federal programs and enrollees.

potentially dangerous controlled substances. For example, FDA published abuse deterrent guidelines for manufacturers to make tamper-resistant products. FDA also requires that drug manufacturers develop and implement Risk Evaluation and Mitigation Strategies (REMS) for certain drugs, including many controlled substances. Also, many State Medicaid programs reported savings linked to implementing lock-in programs, which restrict certain beneficiaries to certain pharmacies or prescribers.

CMS supports States' efforts to improve care for individuals with substance use disorders, including individuals with opioid use disorder. Over the past several years, CMS has provided States with information and program support to enhance coverage for behavioral health conditions. For example, CMS has been providing technical support to States regarding improvements to their substance use disorder systems through the Medicaid Innovation Accelerator Program, which seeks to improve health care for Medicaid beneficiaries by supporting States' ongoing payment and delivery system reform efforts.

**Reducing Abuse and Misuse of Non-controlled Substances.** OIG has performed educational outreach to pharmacists in all 50 States on the dangers of mixing non-controlled medications with opiates as part of the substance abuse spectrum. CMS updated its Drug Diversion Toolkit, which provides education on the diversion of controlled and non-controlled medications.

#### What Needs To Be Done

To fully protect Part D from fraud, waste, and abuse, CMS should take further action and implement OIG's unimplemented recommendations to improve program oversight. For example, OIG recommended that CMS require plan sponsors to report the number of instances of fraud, waste, and abuse in their Part D plans and the corrective actions they subsequently took. This information will enable CMS to monitor the effectiveness of Part D plans' efforts to protect the program. Prescription Drug Monitoring Programs (PDMP) can help curb excessive and inappropriate prescribing. State continuity on requirements for checking the database, and State access to the data for utilization reviews, would assist in strengthening the program. HHS should support efforts to integrate PDMP data into the broader health care system.

HHS should continue to prioritize efforts to reduce opioid misuse and abuse. In Part D, implementing a lock-in program for certain Medicare beneficiaries, the authority for which was recently granted by Congress, would help the program more effectively protect beneficiaries from the harm of inappropriate utilization and also protect the program from drug diversion. With respect to the misuse and abuse of non-controlled substances, CMS and plan sponsors should monitor beneficiary use of a wider range of drugs that are frequently abused. In particular, CMS should expand drug utilization review programs to include additional drugs susceptible to fraud, waste, and abuse, focusing particularly on non-controlled drugs that are abused in conjunction with opioids. Additionally, FDA should continue to assess how best to use the REMS program and other strategies to improve medication safety.

#### Key OIG Resources

- OIG Portfolio, "Ensuring the Integrity of Medicare Part D," June 2015. (<https://oig.hhs.gov/oei/reports/oei-03-15-00180.asp>)
- OIG Data Brief, "High Part D Spending on Opioids and Substantial Growth in Compounded Drugs Raise Concerns," June 2016. (<https://oig.hhs.gov/oei/reports/oei-02-16-00290.pdf>)
- OIG Report, "Medicaid Fraud Control Units Fiscal Year 2014 Annual Report," April 2015. (<https://oig.hhs.gov/oei/reports/oei-06-15-00010.pdf>)



## Top Management Challenge #7: Ensuring Quality of Care and Safety for Vulnerable Populations

### Why This Is a Challenge

Programs operated and administered by HHS touch the lives of nearly all Americans. HHS faces special challenges in serving particularly vulnerable populations, including recipients of nursing home care, hospice care, and home- and community-based services (HCBS); Indian Health Service (IHS) beneficiaries; and children. People may also be especially vulnerable based on the type of conditions they have, such as mental health or substance abuse issues or multiple chronic conditions.

### Key Components of the Challenge

#### Key Components of the Challenge

- Nursing home and hospice care
- Home- and community-based services
- Indian Health Services
- Programs serving children

**Nursing Home Care.** Problems continue with the quality of care and safety of people in nursing facilities, as well as concerns related to preventing abuse of nursing facility residents. For example, in a review of a nursing home's residents who were hospitalized with urinary tract infections, we found that providers did not always render services to residents in accordance with their care plans before the residents were hospitalized with urinary tract infections. Other problems OIG has identified include substandard care causing preventable adverse events, limited compliance with Federal regulations for reporting abuse and neglect, lack of monitoring of hospitalization rates, failure to correct deficiencies identified during the survey process, and employment of caregivers who do not meet relevant licensure requirements.

**Hospice Care.** Hospice care provides comfort for terminally ill beneficiaries and supports family and other caregivers. Problems include inadequate oversight of certification surveys and staff licensure requirements, care planning failures, inadequate medical and nursing care, fraudulent enrollments undertaken without beneficiary consent, and enrollment of beneficiaries who are not terminally ill.

**Home- and Community-Based Services (HCBS).** HCBS, including personal care services (PCS), help beneficiaries continue to live in their homes and avoid costly and disruptive facility-based care. PCS, a critical component of HCBS, serve several targeted populations, including people with mental illness or physical, cognitive, or developmental disabilities. PCS help promote beneficiary choice and preferences, but payment, compliance, and quality vulnerabilities persist and may serve to undermine HCBS goals of offering beneficiaries safe and high quality care outside of an institutional setting. *(For more information on vulnerabilities related to Medicaid PCS, see TMC #2.)* OIG and State Medicaid Fraud Control Units cite high amounts of PCS fraud, some of which involve the abuse or neglect of beneficiaries by PCS attendants that have resulted in deaths, hospitalizations, and less severe degrees of patient harm. Vulnerable beneficiaries may be unable to report the abuse and neglect because of limited communications skills or may be reluctant to report on PCS attendants whom they feel dependent.

**Indian Health Service.** IHS is the principal Federal health care provider for American Indians and Alaska Natives. HHS must ensure adequate access to care and quality of care for IHS beneficiaries. Recruiting and retaining competent clinical staff, aging facilities, hospitals unable to render competent emergency



or high-level care, and limited resources for referred care remain pressing challenges. *(HHS's challenge in combating diversion of opioids and other controlled substances as well as abuse and misuse of prescription drugs is addressed in TMC #6. HHS's challenge in ensuring appropriate use of grant funds is addressed in TMC #5.)*

**Children.** In partnership with the States, HHS operates Medicaid and the Children's Health Insurance Program to provide medical care for over 36 million children, including children from financially needy families, children in foster care, and children with disabilities. The Child Care and Development Fund (CCDF) supports childcare for about 1.4 million children from low-income families while their guardians work or attend school. Ensuring that these intended beneficiaries enjoy access to safely-delivered, high-quality services remains a longstanding challenge for HHS. OIG reviews revealed that many children covered by Medicaid do not receive required dental services, and many children in foster care do not receive required medical services. HHS also operates several programs that provide care for children arriving in the United States without legal status and who are unaccompanied by parents or guardians. *(HHS's challenge in adequately overseeing these programs is addressed in TMC #5.)*

#### Progress in Addressing the Challenge

**Strengthening Processes to Promote Quality Improvement.** HHS continues its efforts to improve the quality of nursing home, hospice, and HCBS programs; care for IHS beneficiaries; and services for especially vulnerable children. In July 2016, the Centers for Medicare & Medicaid Services (CMS) updated a booklet entitled "Preventing Medicaid Improper Payments for Personal Care Services." This guidance addresses problem areas identified by OIG and advises PCS agencies and attendants how to avoid improper payments in the following areas: (1) inadequate documentation for claims; (2) claims for ineligible services; (3) services without adequate supervision; (4) services rendered by unqualified providers or without adequate verification and documentation of qualifications; and (5) claims for home care services supposedly rendered to beneficiaries while the beneficiary was away from home and receiving institutional care.

In August 2016, CMS also issued an Informational Bulletin entitled "Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce" that discussed States' ability to implement basic training for home care workers in topics such as first aid and CPR certification.

HHS continues its efforts to incentivize improved quality of care by linking payment to value and promoting transparency. *(For more information on delivery system reform, see TMC #9.)* In September 2016, CMS published a final rule to improve the quality of nursing home care. The rule updates the requirements for long-term-care facilities that participate in Medicare and implements provisions of the Patient Protection and Affordable Care Act, including requirements for facilities to implement a quality assurance and performance improvement program to ensure that facilities continuously identify and correct quality deficiencies and promote and sustain performance improvement. CMS has also worked to improve the "Five Star Quality Rating System" to better inform beneficiaries and their families about nursing home options. In July 2016, CMS published a final rule on the Skilled Nursing Facility (SNF) Quality Reporting and Value Based Purchasing Programs. CMS continues to develop the SNF Quality Reporting Program (QRP) measures mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014, including reviewing prescribed medication regimens and accounting for potentially preventable hospital readmissions. The rule also establishes penalties for SNFs that fail to submit required quality data to CMS.

HHS is also developing policies and procedures for public reporting of quality data. In July 2016, HHS updated the hospice Quality Reporting Program to include new quality measures and announced a plan to begin publicly reporting hospice quality measures via a Compare site in calendar year 2017. In August 2016, CMS directed State Survey Agency Directors to ensure that nursing homes do not misuse photography or recordings to compromise residents' right to privacy, confidentiality, and dignity. HHS continues to work closely with law enforcement partners at the Department of Justice and through the Federal Elder Justice Interagency Working Group to promote better care for elderly persons and to prosecute providers who subject them to abuse or neglect.

CMS has also been working to develop a new tool to improve person-centeredness of home- and community-based services. The Consumer Assessment of Healthcare Providers and Systems® HCBS Survey helps HCBS programs assess the experiences of beneficiaries. The Survey facilitates comparisons across the hundreds of State Medicaid HCBS programs throughout the country that target different adults with disabilities; including frail elderly, individuals with physical disabilities, people with developmental or intellectual disabilities, those with acquired brain injury, and persons with severe mental illness. The new tool is available for voluntary use in HCBS programs, including both fee-for-service programs as well as managed long-term services and support (LTSS) programs, as part of quality assurance and improvement activities. Aspects of LTSS covered by the survey are staff reliability, communication with staff, getting help from case managers, choice of services, personal safety, adequacy of medical transportation, and community inclusion and empowerment.

HHS has expressed its commitment to improving quality of care in IHS, especially in the Great Plains where recent reports of quality failures have been most pronounced. Recently, HHS created the Executive Council on Quality Care to improve patient safety at IHS hospitals and clinics. IHS' own quality improvement plans include development of a new Quality Framework and establishment of an Office of Quality in IHS Headquarters. IHS has also undertaken a survey initiative to assess IHS hospitals' compliance with conditions of participation and will track resulting performance data. IHS is also undertaking training initiatives for Area Office staff, service unit leaders, and hospitals, the latter with assistance from the Joint Commission. Additionally, IHS and CMS have committed to continue supporting IHS hospital improvement through the Quality Improvement Network – Quality Improvement Organization and Hospital Engagement Network programs.

In 2014, Congress reauthorized the Child Care and Development Block Grant Act. The Act sets basic health and safety standards for CCDF-funded childcare, requires staff background checks, and requires States to monitor childcare programs serving CCDF-funded children annually. HHS continues efforts to ensure that children enrolled in Medicaid can access Medicaid-covered services, including dental care. These efforts include assistance for States and requirements for States to establish access monitoring review plans.

***Protecting Beneficiaries from Dishonest and Potentially Dangerous Providers.*** Successful enforcement activities continue to identify providers and grantees who violate program rules and prevent them from misappropriating additional funds or harming program beneficiaries. In June 2016, a national health care fraud takedown resulted in civil and criminal charges against 301 individuals, including numerous Medicaid HCBS providers. In July 2016, a national operation to combat CCDF fraud generated 18 prosecutions.

Sometimes, OIG determines that providers have rendered such inferior care that protecting the programs and beneficiaries going forward necessitates excluding those providers from serving program

beneficiaries. In other situations, OIG determines that the programs and beneficiaries are better served by allowing the offending provider to continue serving beneficiaries but under close supervision to ensure that future care meets safety and quality standards. To achieve this goal, OIG invests substantial efforts in helping providers improve. OIG has developed an innovative quality-oriented corporate integrity agreement (CIA) process to work with providers so they may better serve beneficiaries. OIG has placed nearly 40 nursing home companies (covering more than 900 facilities) under CIAs that include quality-monitoring provisions designed to ensure that beneficiaries receive the care they deserve. For example, one dental chain that targeted children enrolled in Medicaid was initially placed under a CIA to address substandard care. However, when the provider failed to meet the terms of the CIA and quality-of-care problems persisted, the CIA was terminated and the provider was excluded from further participation in the Federal health care programs.

#### **What Needs To Be Done**

HHS must strengthen procedures to ensure that providers and grant recipients comply with all relevant program rules and deliver safe and high-quality services to the programs' intended beneficiaries. Specifically, HHS should continue to prioritize quality of care in nursing homes and hospices as well as the care rendered as HCBS, with particular focus on PCS. HHS should monitor how often nursing home residents are hospitalized and develop additional resources to help providers avoid adverse events. In addition, HHS should improve internal controls and offer better guidance and training for surveyors to ensure that nursing homes with recorded quality and safety issues correct their deficiencies. CMS should improve coordination with State agencies to ensure that care providers meet relevant licensure requirements. HHS should also improve hospice oversight by (1) increasing physician involvement in decisions regarding general inpatient care, (2) establishing additional remedies for poor-performing hospices, (3) educating providers and beneficiaries about hospice enrollment requirements, and (4) developing and disseminating model text for hospice election statements. HHS should also continue developing policies that effectively link payment to quality.

Ensuring high-quality HCBS and enabling beneficiaries to avoid institutionalization relies heavily on appropriate PCS. CMS must do much more to address vulnerabilities in HCBS, such as PCS. As Medicaid expands, so too will beneficiaries' reliance on HCBS as they seek to avoid institutional care settings. As CMS continues its work to expand access to HCBS, it should also focus on strategies to prevent fraud, waste, and abuse and safeguard beneficiaries' safety. CMS should follow through on commitments to improve PCS program integrity by promulgating regulations and issuing clarifying guidance to States on the range of vulnerabilities that expose beneficiaries to risk of unsafe or suboptimal care.

HHS should ensure the integrity of Medicaid-funded PCS by establishing minimum Federal qualification standards for providers that are based on the needs of the individual being served; improving CMS's and States' ability to monitor billing and quality of care; and issuing operational guidance for claims documentation, beneficiary assessments, person-centered plans of care, and supervision of personal care attendants when hired by an agency. For self-directed programs in which a beneficiary directs his or her own PCS, CMS and the States should improve oversight of controls to ensure individual health and welfare and financial integrity. HHS should also issue guidance to States regarding adequate prepayment controls and help States access data necessary to identify overpayments.

HHS must better oversee IHS hospitals to identify and rectify quality issues and help hospitals implement data-driven quality improvement methods. Specifically, IHS should (1) implement a quality-focused compliance program, (2) establish standards for Area Office/Governing Board oversight activities, (3) set

hospital performance metrics, and (4) better train hospital administrators and staff. In addition, CMS should conduct more frequent surveys of non-accredited hospitals.

The Administration for Children and Families must fully implement its new authorities to ensure safer CCDF-funded childcare. HHS should develop a comprehensive plan to ensure children's access to Medicaid-covered dental services, such as by working with States to (1) develop and achieve service benchmarks, (2) identify areas of provider shortages and address barriers to Medicaid participation, and (3) analyze payment policies.

#### Key OIG Resources

- OIG Report, "Personal Care Services: Trends, Vulnerabilities and Recommendations for Improvement – A Portfolio," November 2012. (<http://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf>).
- OIG Report, "Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care," October 2016. (<https://oig.hhs.gov/oei/reports/oei-06-14-00011.asp>)
- OIG Report, "West Carrol Care Center Did Not Always Follow Care Plans for Residents Who Were Later Hospitalized with Potentially Avoidable Urinary Tract Infections," June 2016. (<https://oig.hhs.gov/oas/reports/region6/61400073.asp>)
- OIG Report, "Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries," February 2014. (<http://oig.hhs.gov/oei/reports/oei-06-11-00370.asp>)
- OIG Report, "Puerto Rico Child Day Care Centers Did Not Always Comply With Commonwealth Health and Safety Requirements," September 2015. (<https://oig.hhs.gov/oas/reports/region2/21402001.asp>)

## Top Management Challenge #8: Operating and Overseeing the Health Insurance Marketplaces

### Why This Is a Challenge

The Health Insurance Marketplaces (Marketplaces), also known as health insurance Exchanges, are critical components of the health care reforms enacted through the Patient Protection and Affordable Care Act.

Implementation, operation, and oversight of the Marketplaces were among the most significant challenges for HHS in previous years and continue to present a top management and performance challenge.

The Marketplaces involve complex regulatory, operational, and technological challenges. Among these are effective communication and coordination between and among all internal and external parties with Marketplace responsibilities, including within HHS and with contractors, issuers, and partners in State and Federal Government. Effective coordination with the Internal Revenue Service (IRS) is particularly important for sound administration of the premium tax credit program—a refundable tax credit that helps eligible individuals and families with low or moderate income afford health insurance purchased through a Marketplace. In addition, the Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring that State Marketplaces comply with Federal requirements and provide complete, accurate, and timely data used for Federal payments. Further, CMS must take appropriate steps to promote compliance by Qualified Health Plans (QHP) with Federal requirements, including network adequacy and non-discrimination requirements. CMS must also take appropriate steps to ensure that individuals are enrolled in the correct insurance program (e.g., Medicare, Medicaid, or private insurance) and to prevent the improper influence of individuals when choosing insurance.

### Key Components of the Challenge

- Payment accuracy
- Eligibility determinations
- Management and administration
- Security and privacy of information systems

### Key Components of the Challenge

**Payments.** Ensuring sound expenditure of taxpayer funds for insurance affordability and other Marketplace purposes poses a substantial management challenge, and OIG found evidence of early deficiencies. For example, CMS's internal controls did not effectively ensure that payments for the advance premium tax credit program were made only for enrollees who paid their monthly premiums. Continued attention is warranted, especially given the introduction of an automated policy-based payment system at the Federal Marketplace and the continued use of interim solutions and manual systems at the State Marketplaces. Effective management of the premium stabilization programs is important because of these programs' impact on the private health insurance market. Attention also must be paid to expenditures of HHS funds used by State Marketplaces for grants and contracts.

**Eligibility.** Accurate eligibility determinations ensure that only eligible consumers are able to enroll in health plans and receive insurance affordability benefits during open and special enrollment periods. To appropriately determine eligibility, CMS must have effective internal controls and accurately and quickly resolve inconsistencies between applicant-reported information and Government databases. OIG and the Government Accountability Office have found vulnerabilities in CMS's eligibility verification and enrollment processes and resolution of inconsistencies.

**Management and Administration.** Management and administration of the Federal and State Marketplaces require, among other things, clear leadership, disciplined operations, and effective strategies and communication. An OIG review of the implementation of Healthcare.gov (the website consumers use to apply for insurance through the Federal Marketplace) identified management deficiencies that contributed to the initial breakdown of the website, as well as improved management afterwards. OIG identified lessons learned from this experience that HHS should continue to apply to the operation of the Federal Marketplace, including the automated policy-based payment system and other large-scale projects. OIG has also made recommendations to CMS to improve its acquisition planning and procurement, contract monitoring, and administration of payments for Marketplace contracts. *(For further information on contract administration, see TMC #4.)* In addition, some Consumer Oriented and Operated Plans (CO-OPs) have ceased operation, posing an additional challenge for HHS.

**Security.** Protecting the confidentiality and ensuring the integrity of consumers' personal information and Marketplace information systems is paramount. Effective operation of the Marketplaces requires rapid, accurate, and secure integration of data from numerous Federal and State sources, issuers, and consumers. HHS must vigilantly guard against intrusions and continuously assess and improve the security of Marketplace-related systems, including, among others, the Data Services Hub, a conduit through which a Marketplace sends and receives electronic data from multiple Federal agencies, and the Multidimensional Insurance Data Analytics System, a data warehouse and repository. *(For more discussion of information privacy and security, see TMC #3.)*

#### Progress in Addressing the Challenge

CMS implemented several core management principles identified in OIG's review that enabled the organization to improve the HealthCare.gov website as well as agency management and culture. In addition, CMS has reported progress in Marketplace operations, including implementing automated policy-based payments for the Federal Marketplace in May 2016; implementing parallel processing and multiple levels of review of financial assistance payments information; working to develop a strategic and unified view of Marketplace procurement and costs; and developing a strategy to improve Marketplace program integrity. As part of its strategy to improve program integrity, CMS has established standards for terminating or suspending agreements between agents and brokers and the Federal Marketplace in cases of fraud or conduct that may cause consumer harm. CMS is also developing outreach and education campaigns designed to inform consumers, agents, and brokers about the dangers of identity theft. CMS reports that it has taken steps to tighten eligibility standards and processes for special enrollment periods.

Additionally, CMS has coordinated with entities across and beyond HHS to improve the accuracy of eligibility and payment data. CMS reported that it updated its Standard Operating Procedures with additional directives to ensure that its Federal Marketplace eligibility support workers can resolve applicant inconsistencies of all types. Further, CMS has developed additional tools to help States report on their eligibility and enrollment processes and to oversee States' plans for addressing unresolved applicant inconsistencies. CMS also reported having regular communications with the IRS and the Department of the Treasury to validate payment information, conduct improper payment risk assessments to determine areas that might affect the accuracy of financial assistance payments, and provide technical and other support to the State Marketplaces. CMS also issued a request for information seeking public comment on concerns that some providers and organizations may be steering people eligible for Medicare and/or Medicaid into QHPs to obtain higher reimbursement rates.

**What Needs To Be Done**

HHS should continue to apply core management principles—including designating clear leadership, integrating policy and technology work, and continuously learning—to improve its operations and oversight of the Federal Marketplace, particularly the eligibility, administrative, and financial management functions. CMS should also address OIG recommendations to improve internal controls. Vulnerabilities in CMS's business processes must be addressed to ensure accurate and timely initial payments and reconciliations of payments. Additionally, CMS must focus on effective management and integrity of the premium stabilization programs. This includes validating information received from issuers to ensure that it is complete, accurate, and timely for payment purposes.

CMS must ensure that all pathways for enrollment operate with integrity, consumers are not improperly influenced in their selection of insurance, and consumers' personal information is secure. Vigilant monitoring and testing of systems and rapid mitigation of identified vulnerabilities are essential. CMS must also focus attention on the sound operation of financial assistance programs for beneficiaries. Consumers and issuers must receive accurate Marketplace information, including information relevant for tax purposes, such as Form 1095A tax forms. Furthermore, Marketplaces must continue to protect personally identifiable information and strengthen security controls.

CMS must also continue to work with States to improve State Marketplace operations, including payment systems, and to ensure compliance with Federal requirements for Marketplaces and health plans. HHS must continue to pay attention to the financial and operational challenges faced by CO-OPs. CMS must monitor for and address fraud, waste, and abuse risks in Marketplace programs. CMS must respond quickly and effectively to credible allegations of fraud, working with QHPs and with partners at the Federal and State level to hold those involved accountable.

**Key OIG Resources**

- For links to OIG's portfolio of reports on the Federal and State Marketplaces, as well as OIG's Health Reform Oversight Plan, please see the Patient Protection and Affordable Care Act Reviews section on OIG's website: <https://oig.hhs.gov/reports-and-publications/aca/>.



## Top Management Challenge #9: Managing Delivery System Reform and Strengthening Medicare Advantage

### Why This Is a Challenge

A paradigm shift is underway in the Nation's health care system—both public and private—to improve patient care and reduce wasteful spending through heightened focus on quality of care rather than quantity of care. The pace of change is rapid and the magnitude substantial. New models are being introduced that focus on rewarding the delivery of high-value health care and promoting innovative care redesigns that provide patients with better coordinated care. These models are intended to incorporate new understandings of medicine, social science, population health, technology, data analysis, and behavioral incentives. Medical, mental health, and social services are being integrated in new ways.

### Key Components of the Challenge

- Implementing Medicare's Quality Payment Program
- Managing the CMS Innovation Portfolio
- Strengthening Medicare Advantage

For HHS, this shift—propelled by reforms under the Patient Protection and Affordable Care Act, Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and other statutes—affects all parts of Medicare, as well as Medicaid and public health programs. Stakeholders include patients, providers, vendors, managed care organizations, private payers, administrative contractors, State agencies, and taxpayers. HHS is investing significant resources in developing evidence-based tools, realigning provider and beneficiary incentives, testing new coordinated and integrated care designs, promoting meaningful use of electronic health records (EHRs) and other technologies, and enhancing patient engagement and access to health information.

Delivery system reform in a highly complex environment requires concurrent, sustained, and multifaceted planning, execution, and oversight. To participate successfully in new models, providers and others must commit resources and reshape the delivery of care. Models often involve new types of caregivers as well as individuals and entities undertaking new roles and responsibilities in Federal health care programs. HHS must effectively educate and oversee both experienced participants and new entrants into these programs.

### Key Components of the Challenge

**Implementing Medicare's Quality Payment Program.** MACRA revamped Medicare's physician reimbursement system, affecting physicians and other clinicians reimbursed under the Medicare Physician Fee Schedule. The new Quality Payment Program (QPP) introduces into physician reimbursement two new mechanisms linked to quality and efficiency: (1) a Merit-Based Incentive Payment System (MIPS) and (2) alternative payment models (APMs). To meet statutory deadlines, much must be accomplished quickly. This novel and complex program presents substantial policy, administrative, operational, logistical, and technological challenges. The Centers for Medicare & Medicaid Services (CMS) must consolidate three existing incentive programs into MIPS and craft advanced APMs suitable for physicians with various practice characteristics and levels of operational readiness. In so doing, CMS must be mindful of administrative burden. Notably, there is concern that small and rural providers may need assistance navigating the transition. Physicians must prepare for significant changes in reimbursement methodology, reporting, and, depending on circumstances, delivery of care and workflow. Quality measurement is a key component of the QPP. Challenges



highlighted in HHS's recent Quality Measure Development Plan<sup>41</sup> for the QPP include closing known measurement and performance gaps; harmonizing and aligning measures across programs, settings, and payers; and refining measure development. CMS has signaled plans to finalize measure sets in annual rulemaking.

**Managing the CMS Innovation Portfolio.** The diverse CMS innovation portfolio poses a significant management challenge for HHS. Comprising dozens of new models in various stages of development and implementation, the portfolio touches on virtually every aspect of health care delivery and experiments with a variety of payment structures, including shared savings, episode-based payments, population-based payments, capitation, and value-based purchasing. Many new payment structures are hybrids involving both traditional and new types of payments, giving rise to additional challenges in managing risk. Many models involve novel business arrangements among providers and new incentives to promote patient engagement in their own care. These arrangements and incentives also give rise to challenges for risk management. CMS operates both voluntary models and models that are mandatory in designated geographic areas; mandatory models pose unique challenges in ensuring provider readiness.

HHS must ensure that Medicare realizes benefit from the Government's substantial investment in designing, testing, and implementing new models, including the Center for Medicare & Medicaid Innovation's (CMMI) 10-year, \$10 billion budget. Perhaps equally challenging is ensuring that models are viable in light of providers' substantial investments in infrastructure and care redesign. Responsibility for administering and overseeing new models is shared across several CMS components, including CMMI and the Center for Program Integrity. CMS leverages expertise across HHS through partnerships with other HHS operating divisions. These collaborations within and outside CMS require shared vision, clear communications, and continuous coordination.

**Strengthening Medicare Advantage.** Approximately 30 percent of Medicare beneficiaries are enrolled in Medicare Advantage (MA), a three-fold increase since 2004. Ensuring a sound MA program is essential to meeting intended coverage, access, quality, and cost goals. OIG work has identified challenges in the MA program with respect to the precision and use of data, payment accuracy, and program integrity, including vulnerabilities at both the plan and provider levels. CMS estimated for FY 2015 that 9.5 percent of payments to MA organizations were improper, mainly due to insufficient documentation to support diagnoses submitted by MA organizations.<sup>42</sup> Notwithstanding these vulnerabilities, MA organizations have the potential to increase efficiency and quality through better coordinated care, aligned incentives, and performance measurement. HHS is developing new models for MA, including a Value-Based Insurance Design model. *(For more information on improving the effectiveness of Medicaid managed care, see TMC #2.)*

#### Progress in Addressing the Challenge

**Implementing the QPP.** CMS is making steady early progress in implementing the QPP, including recently issued final program regulations. HHS has begun issuing other program policies and guidance, including the Office of the National Coordinator for Health Information Technology's guidance for measuring interoperability and health information exchange. CMS is deploying an integrated policy and

<sup>41</sup> <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf>

<sup>42</sup> GAO Report: <http://www.gao.gov/assets/680/676441.pdf>; Annual Financial Statement Audit <http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf>

technology team to plan and execute the QPP. CMS is testing user-centered IT designs and planning education and technical assistance initiatives to promote clinician acceptance of, and readiness for, the QPP. In April 2016, CMS released a solicitation for direct technical assistance to support implementation of the QPP. CMS more recently announced a new, long-term initiative to increase clinician engagement, including an 18-month pilot program to reduce medical review for certain physicians practicing within specified alternate payment models with two-sided risk.

**Designing and Assessing Models.** CMS is compiling a growing roster on its website of early results from, and evaluations of, new programs and models. For example, CMS reported that Medicare accountable care organization (ACO) programs, comprising over 400 ACOs, generated total gross program savings of more than \$466 million for Medicare in 2015; CMS also reported improvements in quality performance.<sup>43</sup> Further, CMS reported second-year results for the Independence at Home (medical home) Demonstration of an average savings of \$1,010 per beneficiary, with all participating practices improving quality from the first performance year in at least two of the six quality measures. Results vary across models, with some more promising than others.

CMS continues to test initiatives to speed adoption of best practices, accelerate development of new models, and reform Medicaid and the Children's Health Insurance Program, among others. Models include multiple types of ACOs, primary care medical homes, and bundled payment initiatives. More recently, CMS has been developing and refining models that will qualify as advanced APMs under the QPP. HHS is supporting the Health Care Payment Learning and Action Network to collaborate on aligning reforms across health care sectors. CMS issued regulations for an expanded Medicare Diabetes Prevention Model. CMS continues to provide guidance and education to model participants, as well as to state Medicaid agencies engaged in reforms through CMMI's Medicaid Innovation Accelerator Program, and has taken steps to include in new models program integrity safeguards, including transparency of data and monitoring for indicators of abuse or gaming.

In March 2016, HHS announced that it met, earlier than scheduled, its goal of tying 30 percent of traditional Medicare payments to APMs by the end of 2016. HHS aims to increase this amount to 50 percent by 2018.

**Strengthening Medicare Advantage.** CMS is using audits to oversee, among other things, MA organizations' implementation of programs to detect, correct, and prevent fraud, waste, and abuse, which are required by their compliance plans. CMS has issued guidance on sharing information between CMS contractors and with other program integrity stakeholders, such as State agencies, to more effectively coordinate efforts to identify and investigate fraud. HHS has stated a goal of having all MA contracts audited annually. CMS has taken steps to incorporate recovery audit contractors into MA, as required by statute.<sup>44</sup> CMS has enhanced the transparency of information about MA plans by publicly reporting on its website additional data, including information about grievances filed with plans and plans' oversight of sales agents and brokers. CMS announced changes to the Star Ratings system, developed through a public process, aimed at better accounting for costs of caring for enrollees. Further, CMS has developed a Network Management Module to help assess network adequacy.

<sup>43</sup> <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-25.html>

<sup>44</sup> GAO Report: <http://www.gao.gov/assets/680/676441.pdf>

**What Needs To Be Done**

**Continue Implementing the QPP.** Physician payment reform under MACRA will require sustained focus. For a successful transition, CMS must address policy, infrastructure, data systems, oversight, and provider education needs. Physician representatives have identified challenges, including complexity of reporting and measurement, scope and availability of APMs, provider education, daunting timelines, infrastructure investments, new business requirements, and administrative burden. CMS should allocate sufficient resources to ensure issuance of timely and clear program regulations and guidance and to provide meaningful education and technical assistance. In addition to well-functioning, physician-oriented websites, CMS must ensure that it has fully operational back-end payment and data systems for the QPP. CMS must coordinate with the Office of the Assistant Secretary for Planning and Evaluation and the Physician-Focused Payment Model Technical Advisory Committee on the development of APM opportunities submitted by physicians. CMS needs to develop quality measures as outlined in the Quality Measure Development Plan and monitor for any unintended impacts the quality measures have on Medicare beneficiaries. CMS needs to ensure that its medical records review reduction pilot program operates in a manner that protects the Medicare program from fraud and abuse.

**Effectively Manage and Oversee New Models.** CMS must continue to manage its growing portfolio of complex models and innovations to ensure they achieve their intended quality of care and efficiency outcomes. CMS must issue clear guidance on program requirements; administer (or contract for) financial, beneficiary alignment, and other systems necessary for effective operations; and test, evaluate, and verify model progress and outcomes. Attention should be paid to the policy, evaluative, compliance, and practical day-to-day challenges for CMS and providers of concurrent participation in multiple models. Further, CMS must clearly define actionable and meaningful quality measures and ensure that they, in fact, measure what CMS intends them to measure to achieve desired quality goals. CMS should carefully monitor for successes and benefits that can be scaled and replicated, as well as for potential problems—including inefficiencies and misaligned incentives. As the testing of multiple models matures, CMS will need to effectively manage the transition from testing a model to its expansion, as appropriate.

New models rely significantly on data, EHRs, and technology. CMS must ensure that data collected and provided for new payment models are complete, accurate, timely, and secure and that new technologies, such as telemedicine, achieve their intended results. Data from providers and others must be integrated and shared across models within HHS and with stakeholders, as appropriate. *(For more information on the challenges associated with electronic information and health IT, see TMC #3.)* To the extent that resource, cost, and quality performance are measured on the basis of Medicare Parts A and B claims data, CMS must ensure the soundness and reliability of such data. CMS should adopt sound record retention and documentation practices for all models.

CMS must monitor for program integrity risks in new models, incorporate safeguards tailored to specific risks in particular models, and assess the effectiveness of the safeguards it employs. Detected program integrity problems should be remediated promptly and safeguards strengthened to prevent program and patient abuse or gaming. Sharp attention to program integrity is especially important for models that introduce new payment incentives, which might lead to new fraud schemes, or for which waivers of payment or fraud and abuse laws may have been issued under sections 1899(f) or 1115A of the Social Security Act. As a critical element of program integrity, CMS must maintain accurate historical and real-time information about new models, including, for example, information about providers and beneficiaries. *(For more information on fraud and abuse in Medicare Parts A and B, see TMC #1.)*

**Strengthen Medicare Advantage.** CMS should continue to focus on ensuring that MA plan enrollees have access to and receive the services to which they are entitled and that those services are of appropriate quality. CMS must strengthen the MA program to ensure that benefits are provided only to eligible beneficiaries. Further, CMS must ensure that data and other information related to payment from providers and plans are available for fraud detection and prevention. CMS must use data effectively to ensure payment accuracy and to review MA organizations' performance. Ensuring the accuracy and integrity of risk-adjustment and other data used to establish payment rates is also critical to protect against gaming or abuse and reducing the payment error rate. HHS should take steps to address the obstacles to accurate risk-adjustment payments and recovery of improper payments recently identified by the Government Accountability Office.<sup>45</sup> Finally, CMS will need to oversee new models within the MA program to ensure that they meet intended quality of care and cost-containment goals.

#### Key OIG Resources

- OIG Accountable Care Organization Resource Page: (<https://oig.hhs.gov/compliance/accountable-care-organizations/index.asp>)
- OIG Report, "Observations From our Review of CMS' Administration of the First Performance Year of the Pioneer Accountable Care Organization Payment Model," May 2016. (<https://oig.hhs.gov/oas/reports/region1/11300509.pdf>)
- OIG Report, "Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012," April 2014. (<https://oig.hhs.gov/oas/reports/region7/71301125.pdf>)
- OIG Report, "CMS Regularly Reviews Part C Reporting Requirements Data, but Its Followup and Use of the Data are Limited," March 2014. (<https://oig.hhs.gov/oei/reports/oei-03-11-00720.pdf>)
- OIG Report, "MEDIC Benefit Integrity Activities in Medicare Parts C and D," January 2013. (<https://oig.hhs.gov/oei/reports/oei-03-11-00310.pdf>)

<sup>45</sup> GAO Report: <http://www.gao.gov/assets/680/676441.pdf>

## Top Management Challenge #10: Ensuring the Safety of Food, Drugs, and Medical Devices

### Why This Is a Challenge

HHS, through the Food and Drug Administration (FDA), must ensure the safety, efficacy, and security of our Nation's food supply, drugs, biologics, and medical devices. FDA is also responsible for regulating tobacco products. Areas of particularly high risk include food safety, drug compounding, a complex drug supply chain, and improper marketing activities.

### Key Components of the Challenge

- Food safety
- Drug compounding
- Complex drug supply chain
- Improper marketing

### Key Components of the Challenge

**Food Safety.** Foodborne illnesses, such as those caused by *Salmonella*, *Listeria monocytogenes*, and *E. coli*, pose a continuing public health threat.

Oversight is complicated by the immense diversity of the global food supply: 20 percent of our vegetables come from abroad, as does 50 percent of our fresh fruit, and more than 80 percent of our seafood.<sup>46</sup> When a problem with the U.S. food supply is identified, FDA must ensure that the problem is addressed using its various administrative tools and enforcement authorities. After reviewing 30 recalls selected on the basis of their risk factor, OIG recently alerted FDA that consumers remained at risk of illness or death for several weeks after FDA was aware of a potentially hazardous food in the supply chain.

**Drug Compounding.** The potential danger of improperly compounded drugs drew national attention in 2012 when drug injections meant to be sterile were contaminated during the compounding process and resulted in a deadly fungal meningitis outbreak. Compounded drugs are not subject to FDA's premarket approval process, in which FDA evaluates the safety and efficacy of conventionally-manufactured drugs. FDA continues to identify serious problems at facilities that compound drugs, the vast majority of which do not register with the FDA.<sup>47</sup> (For information on rising costs and potential fraud involving compounded drugs, see TMC #6.)

**Complex Drug Supply Chain.** The drug supply chain is growing increasingly complex, not only domestically but globally. This makes it difficult to track products to their sources in case of a recall and complicates FDA's task of ensuring the integrity of these products. Multiple manufacturers may be involved in the various stages of production. Currently, about 40 percent of prescription drugs sold in the United States and 80 percent of active ingredients used in drugs are made in other countries.<sup>48</sup> Once drugs are produced, multiple parties may distribute or repackage the finished product. Drugs from unapproved sources can also enter the U.S. drug supply chain. Disruptions in the supply chain can lead to problems with patient access to needed prescription drugs.<sup>49</sup>

**Improper Marketing Activities.** FDA approves the marketing of drugs, biologics, and medical devices for specific uses after determining that the products are safe and effective for those uses. Once approved,

<sup>46</sup> <http://www.fda.gov/InternationalPrograms/FDABeyondOurBordersForeignOffices/> (accessed October 26, 2016).

<sup>47</sup> <http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm339771.htm>

<sup>48</sup> <http://www.fda.gov/NewsEvents/Testimony/ucm271073.htm>

<sup>49</sup> <https://aspe.hhs.gov/sites/default/files/pdf/108986/ib.pdf>

qualified medical practitioners may prescribe them for any use, including uses not approved by the FDA. However, individuals and manufacturers are prohibited from marketing products for unapproved uses. In general, the Federal health care programs do not cover unapproved products. Improper marketing activities can put patients at risk of receiving inappropriate or harmful care and lead to fraudulent claims for payment from Federal health care programs. *(For more information on drug diversion and utilization of prescription drugs, see TMC #6.)*

#### Progress in Addressing the Challenge

**Food Safety.** FDA continues to implement its enhanced food-safety authorities statutorily granted in 2011 by the Food Safety Modernization Act. In 2015 and 2016, the Agency finalized rules on preventative controls for human food, current good manufacturing practices and preventative controls for animal food, produce safety, accredited third-party certification, sanitary transportation of human and animal food, protection against intentional adulteration, and the foreign supplier verification program. FDA's food scientists have also worked to further develop and broaden the use of whole genome sequencing technologies to better differentiate between organisms and strains to identify and prevent foodborne illnesses. FDA continues collaboration with State regulatory and public health partners to establish an integrated national food safety system and has initiated new efforts to incorporate produce safety. Additionally, as part of FDA's effort to leverage the comparable food safety oversight conducted by foreign partners, FDA entered into food safety systems recognition agreements with New Zealand in December 2012 and Canada in May 2016.

**Drug Compounding.** In 2013, the Compounding Quality Act clarified and amended FDA's authority to oversee compounding, including providing a new pathway for compounders to register with FDA as outsourcing facilities. Outsourcing facilities that compound drugs in accordance with the conditions set forth in the Compounding Quality Act are eligible for exemptions from certain FDA requirements, but are held to manufacturing quality standards similar to those applicable to conventional drug manufacturers. FDA continues to work to fully implement the Compounding Quality Act, and the Agency has issued numerous policy and guidance documents applicable to outsourcing facilities and other compounders. FDA also continues to inspect compounding facilities; oversee recalls of compounded drugs for contamination or lack of sterility assurance; and issue warning letters to compounders that violate the law.

**Complex Drug Supply Chain.** The Drug Supply Chain Security Act created the basis for building an electronic, interoperable system to identify and trace certain prescription drugs as they are distributed in the United States, whether they originate in this country or not. FDA has issued guidance to establish initial standards for the interoperable exchange of product tracing information and also created a publicly available database of authorized wholesale distributors of traceable prescription drugs. OIG is reviewing wholesale distributors' and dispensers' early experiences in exchanging product tracing information.

**Improper Marketing Activities.** To protect patients and reduce the waste of Federal health care program money, OIG, FDA, and their law enforcement partners have pursued numerous enforcement actions against manufacturers for improperly marketing drugs, biologics, and devices. In addition, FDA has engaged in both outreach and enforcement actions on unapproved drugs and devices, including unapproved products from foreign sources. FDA has also undertaken efforts to warn consumers, medical practitioners, and others about the medical risks associated with importing unapproved drugs. FDA, OIG, and their law enforcement partners continue to investigate and prosecute physicians and

suppliers that distribute unapproved drugs and devices. FDA collaborates with international partners and has introduced improved border screening to enhance oversight of imported products.

#### What Needs To Be Done

**Implementation.** FDA must continue taking steps to fully implement its statutory authorities and develop robust policies and procedures to ensure that problems with the Nation's food supply are addressed in a timely manner. OIG has recommended that FDA remedy identified weaknesses in recall procedures and better ensure that recalls are promptly initiated, monitored, and closed out. FDA must continue to implement its new authorities to enhance oversight of drug compounders and better ensure the safety of compounded products, including by inspecting drug compounders and pursuing regulatory action when deficiencies are identified. FDA must also continue to implement its new authorities in tracking drugs through the supply chain.

**Oversight.** FDA must ensure that drug supply chain partners comply with product tracing requirements. FDA has twice delayed its enforcement of certain product tracing requirements for wholesale distributors and dispensers due to their requests for additional time to implement product tracing requirements. FDA must also continue combating improper marketing practices and importation of unapproved drugs for commercial distribution in the United States. OIG, in cooperation with the Department of Justice and other law enforcement partners, will continue to employ investigative and enforcement authorities to protect Federal health care programs and beneficiaries from these potentially-dangerous products.

OIG will continue monitoring the changing legal landscape, legislative developments, and FDA's oversight of food, drugs (both prescription and over-the-counter), biologics, dietary supplements, medical devices, and tobacco, and adjust priorities as needed.

#### Key OIG Resources

- OIG Report, "Early Alert: The Food and Drug Administration Does Not Have an Efficient and Effective Food Recall Initiation Process," June 2016. (<http://oig.hhs.gov/oas/reports/region1/11501500.asp>)
- OIG Report, "High Part D Spending on Opioids and Substantial Growth in Compounded Drugs Raise Concerns," July 2016. (<https://oig.hhs.gov/oei/reports/oei-02-16-00290.asp>)
- OIG Report, "High-Risk Compounded Sterile Preparations and Outsourcing by Hospitals That Use Them," April 2013. (<http://oig.hhs.gov/oei/reports/oei-01-13-00150.asp>)
- OIG Report, "FDA is Issuing More Postmarketing Requirements, but Challenges with Oversight Persist," July 2016. (<https://oig.hhs.gov/oei/reports/oei-01-14-00390.asp>)



**DEPARTMENT'S RESPONSE TO THE OFFICE OF INSPECTOR GENERAL TOP  
MANAGEMENT AND PERFORMANCE CHALLENGES**

DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: Mary K. Wakefield, Acting Deputy Secretary

Subject: FY 2016 Top Management and Performance Challenges Identified by the Office of Inspector General (OIG)

Thank you for the OIG's work in assessing the major management and performance challenges facing the Department of Health and Human Services (HHS). We appreciate the OIG's dedication to helping us improve operations through its audit and investigative work throughout the year.

HHS faces a number of long-term challenges. The suggestions you offer to address our challenges will help us inform and improve decisions related to budgeting, strategic planning, and other critical mission functions. It is critical we find innovative ways to work leaner. Looking ahead, we are committed to building on our progress. We recognize that there is more to be done that will require our organization's sustained attention, action, and improvement. The Department's Operating Divisions continue to focus on serving all Americans by protecting their health, providing essential human services, and promoting the well-being of individuals, families, and communities. The OIG's work will help us do this in the most effective and efficient way possible.

We look forward to cooperating with you and our stakeholders on the continuous improvement of our activities. We are committed to focusing our resources on the issues related to these challenges as we smoothly transition into a new Presidential administration and continue to execute our strategic plan.

/Mary K. Wakefield/

Mary K. Wakefield  
Acting Deputy Secretary  
November 14, 2016



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# Appendices



# A

## In This Section

- Acronyms
- Connect with HHS

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## APPENDIX A: ACRONYMS

A	
AA	Associate of Arts
ACF	Administration for Children and Families
ACO	Accountable Care Organization
ACL	Administration for Community Living
ADA	<i>Anti-Deficiency Act</i>
ADR	Additional Documentation Request
AFR	Agency Financial Report
AHRQ	Agency for Healthcare Research and Quality
AICPA	American Institutes of Certified Public Accountants
ALF	Assisted Living Facility
APG	Agency Priority Goal
APM	Alternative Payment Model
APTC	Advance Premium Tax Credit
ASFR	Assistant Secretary for Financial Resources
ASPR	Assistant Secretary for Preparedness and Response
ATM	Accounting Treatment Manual
ATSDR	Agency for Toxic Substances and Disease Registry
B	
BA	Bachelor of Arts
BBA	<i>Bipartisan Budget Act of 2015</i>
BHCC	Behavioral Health Coordinating Council
BHP	Basic Health Program
BUP	Buprenorphine
C	
CAH	Critical Access Hospital
CAPs	Corrective Action Plans
CBRs	Comparative Billing Reports
CCDBG	<i>Child Care and Development Block Grant Act of 2014</i>
CCDF	Child Care and Development Fund
CCIIO	Center for Consumer Information and Insurance Oversight
CDC	Centers for Disease Control and Prevention
CERT	Comprehensive Error Rate Testing
CFO	Chief Financial Officer
CFO Act	<i>Chief Financial Officers Act of 1990</i>
CFR	Code of Federal Regulations
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CIA	Corporate Integrity Agreement

CIO	Chief Information Officer
CISO	Chief Information Security Officer
CMA	Computer Matching Agreement
CMMI	Center for Medicare and Medicaid Innovation
CMP	Civil Monetary Penalty
CMS	Centers for Medicare & Medicaid Services
CMS-HCCS	CMS Hierarchical Condition Categories
CO-OP	Consumer Oriented and Operated Plan
COTS	Commercial Off-the-Shelf
CPI	Consumer Price Index
CRC	Commercial Repayment Center
CSR	Cost-sharing Reduction
CSRS	Civil Service Retirement System
CY	Current Year
D	
DAP	DATA Act Program Management Office
DATA Act	<i>Digital Accountability and Transparency Act of 2014</i>
DCIA	<i>Debt Collection Improvement Act of 1996</i>
DHS	Department of Homeland Security
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DNP	Do Not Pay
DOD	Department of Defense
DOI	Department of the Interior
DOL	Department of Labor
DRA	<i>Deficit Reduction Act of 2005</i>
E	
EBT	Electronic Benefit Transfer
EHRs	Electronic Health Records
EHS-CCP	Early Head Start-Child Care Partnership
EO	Executive Order
ERM	Enterprise Risk Management
ESRD	End-stage Renal Disease
F	
FACES	Family and Child Experience Survey
FBIP	Financial Business Intelligence Program
FBIS	Financial Business Intelligence System
FBwT	Fund Balance with Treasury
FDA	Food and Drug Administration
FECA	<i>Federal Employees' Compensation Act</i>
FedRAMP	Federal Risk and Authorization Management Program

FERS	Federal Employees Retirement System
FETP	Field Epidemiology Training Programs
FFMIA	<i>Federal Financial Management Improvement Act of 1996</i>
FFS	Fee-For-Service
FGB	Financial Management Governance Board
FICA	<i>Federal Insurance Contributions Act</i>
FISCAM	Federal Information System Controls Audit Manual
FISMA	<i>Federal Information Security Management Act</i>
FITARA	<i>Federal Information Technology Acquisition Reform Act</i>
FMFIA	<i>Federal Managers' Financial Integrity Act of 1982</i>
FPS	Fraud Prevention System
FSIP	Financial Systems Improvement Program
FY	Fiscal Year
<b>G</b>	
GAAP	Generally Accepted Accounting Principles
GAO	U.S. Government Accountability Office
GDP	Gross Domestic Product
GHP	Group Health Plan
GMRA	<i>Government Management Reform Act of 1994</i>
GPRA	<i>Government Performance and Results Act of 1993</i>
GSA	General Services Administration
<b>H</b>	
H5N1	Avian Influenza
HCBS	Home and Community-based Services
HCFAC	Health Care Fraud and Abuse Control
HEW	Department of Health, Education, and Welfare
HFPP	Healthcare Fraud Prevention Partnership
HHA	Home Health Agency
HHS	Department of Health and Human Services
HHSAR	HHS Acquisition Regulation
HI	Hospital Insurance
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	<i>Health Insurance Portability and Accountability Act of 1996</i>
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration

<b>I</b>	
IBNR	Incurred But Not Reported
IHS	Indian Health Service
IP	Improper Payment
IPERA	<i>Improper Payments Elimination and Recovery Act of 2010</i>
IPERIA	<i>Improper Payments Elimination and Recovery Improvement Act of 2012</i>
IPIA	<i>Improper Payments Information Act of 2002</i>
IPT	Integrated Project Team
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
IT	Information Technology
<b>L</b>	
L.m.	<i>Listeria monocytogenes</i>
LTSS	Long Term Services and Support
<b>M</b>	
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MACRA	<i>Medicare Access and CHIP Reauthorization Act of 2015</i>
MARx	Medicare Advantage Prescription Drug
MEDIC	Medicare Drug Integrity Contractor
MICs	Medicaid Integrity Contractors
MIPS	Merit-based Incentive Payment System
MMIS	Medicaid Management Information Systems
MMWR	Morbidity and Mortality Weekly Reports
MR	Medical Review
MRI	Magnetic Resonance Imaging
MSP	Medicare Secondary Payer
MWWG	Material Weakness Working Group
<b>N</b>	
NAL	Naltrexone
NBI	National Benefit Integrity
NBS	NIH Business System
NCCI	National Correct Coding Initiative
NFCSP	National Family Caregiver Support Program
NGHP	Non-Group Health Plan
NIH	National Institutes of Health
NIST	National Institute of Standards and Technology
NPI	National Provider Identifier
<b>O</b>	
OASDI	Old-Age, Survivors, and Disability Insurance

OCR	Office for Civil Rights
OHS	Office of Head Start
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health IT
OPD	Orphan Products Design
OpDiv	Operating Division
OS	Office of the Secretary
<b>P</b>	
PARIS	Public Assistance Reporting Information System
PCS	Personal Care Services
PDE	Prescription Drug Event
PDMP	Prescription Drug Monitoring Programs
PECOS	Provider Enrollment, Chain and Ownership System
PEDIR	Payment Error Related to Direct and Indirect Remuneration
PELS	Payment Error Related to Low Income Subsidy Status
PEMS	Payment Error Related to Medicaid Status
PEPV	Payment Error Related to Prescription Drug Event Data Validation
PERM	Payment Error Rate Measurement
PHS	Public Health Service
PIP	Program Improvement Plan
PMI	Precision Medicine Initiative
PMD	Power Mobility Device
PRRB	Provider Reimbursement Review Board
PSC	Program Support Center
PSNet	Patient Safety Network
PTC	Premium Tax Credit
PUR	Period Under Review
PY	Prior Year
<b>Q</b>	
QHP	Qualified Health Plans
QIOs	Quality Improvement Organizations
QPP	Quality Payment Program
QRIS	Quality Rating and Improvement Systems
QRP	Quality Reporting Program
<b>R</b>	
RAC	Recovery Auditor Contractor

RADV	Risk Adjustment Data Validation
REMS	Risk Evaluation and Mitigation Strategies
RMFOB	Risk Management and Financial Oversight Board
RSI	Required Supplementary Information
<b>S</b>	
SAMHSA	Substance Abuse and Mental Health Services Administration
SECA	<i>Self Employment Contributions Act of 1954</i>
Section 601	<i>Bipartisan Budget Act of 2015</i>
SFFAS	Statement of Federal Financial Accounting Standards
SGR	Sustainable Growth Rate
SMI	Supplementary Medical Insurance
SMRC	Supplemental Medical Review Contractor
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSBG	Social Services Block Grant
StaffDiv	Staff Division
<b>T</b>	
T-MSIS	Transformed Medicaid Statistical Information System
TANF	Temporary Assistance for Needy Families
TAS	Treasury Account Symbol
TMC	Top Management Challenge
Treasury	U.S. Department of the Treasury
<b>U</b>	
UFMS	Unified Financial Management System
U.S.	United States
U.S.C.	United States Code
USSGL	United States Standard General Ledger
<b>V</b>	
VA	Department of Veterans Affairs
VFC	Vaccines for Children
<b>W</b>	
WIOA	<i>Workforce Innovation and Opportunity Act</i>

## APPENDIX B: CONNECT WITH HHS



*The Hubert H. Humphrey Building, headquarters of the U.S. Department of Health and Human Services, was the first federal building dedicated to a living person.*

Thank you for your interest in HHS's FY 2016 AFR. We welcome your comments on how we can make this report more informative for our readers. Please send your comments to:

Mail: U.S. Department of Health and Human Services  
Office of Finance/Office of Financial Reporting and Policy  
Mail Stop 549D  
200 Independence Avenue, S.W.  
Washington, DC 20201

Email: [HHSAFR@hhs.gov](mailto:HHSAFR@hhs.gov)

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